

**Partnerships, Opportunities and Challenges:
A Vision for the Future**

**1994 Cooperating Agencies' Meeting
SUMMARY OF PROCEEDINGS**

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Timothy Wirth, Counselor, U.S. Department of State	
Elizabeth Maguire, Acting Director, Office of Population, USAID	
Steven Sinding, Director, Population Sciences, The Rockefeller Foundation	
Allan Rosenfield, Dean, School of Public Health, Columbia University	

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USAID

Non-USAID

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PARTNERSHIPS, OPPORTUNITIES AND CHALLENGES: A VISION FOR THE FUTURE

Overview

The Office of Population hosted the 1994 Meeting of Cooperating Agencies, entitled "Partnerships, Opportunities and Challenges: A Vision for the Future," from February 22-24, 1994. The meeting provided a valuable forum in which to collectively examine changes in USAID's organization and strategy, key programmatic issues and initiatives in family planning and reproductive health, and implementation issues being addressed by a restructured USAID. The stimulating and productive exchange of information and ideas boosted morale, led to a renewed sense of mission among conference participants, and confirmed USAID's leadership position in the international population arena.

This was the first major meeting of USAID's population Cooperating Agencies (CAs) in over three years and marked the first time population CAs were joined by CAs working in related health areas. The meeting was a key step in the development of the Center of Excellence in Population, Health, and Nutrition (PHN). Planning for the meeting began in July 1993 and was a collaborative process, involving the Office of Population, other offices in the Bureau for Global Programs, Field Support and Research (particularly the Office of Health), regional bureaus, and CAs.

Participation

Nearly 700 people attended the initial three days of the meeting. Participants included representatives from CAs' headquarters and field offices; representatives from USAID/Washington offices; field staff from over 50 USAID Missions; colleagues from the State Department and other government agencies; congressional staff; PVOs and NGOs working in population, reproductive health, and related fields; key donors; and environmental and women's health advocacy groups. Many of these groups are new partners with USAID's population program, and the meeting provided an important opportunity to welcome them into the network.

Structure and Content

The three-day meeting featured plenary speeches by USAID's leadership; invited papers by leaders in the field, such as Steven Sinding and Allan Rosenfield; presentations by Counselor Timothy Wirth and congressional staff; and technical break out sessions. A common theme of these sessions was the importance of marrying the global with the end-user perspective. Many speakers highlighted USAID's leadership and comparative advantage in the population and health sector.

Two days of supplementary meetings followed the three-day core meeting. "Professional Development Day" (February 25) was organized by the CAs and focused on technical presentations covering a wide range of family

planning and reproductive health issues. This was the first such event organized by the CAs. A PHN Officers meeting—the first such interregional meeting in a decade—took place on February 28.

The Discussion Process

The three-day core meeting was organized as follows:

Day 1 was devoted to an overview of changes in USAID and its new directions, strategies, and guidelines. Agency leaders addressed these important issues and, in particular, described the new Bureau for Global Programs, Field Support and Research, its functions in support of technical programs, and the relationships among the Global Bureau, regional bureaus, and Missions. Afternoon small group discussions gathered feedback from participants regarding the reorganization and policy changes and their effects on population and reproductive health programs. These concerns were compiled, briefly outlined at the beginning of Day 2, and addressed in subsequent plenaries and break out groups during Days 2 and 3.

Day 2 dealt with programmatic issues and initiatives. Eighteen break out groups highlighted critical family planning and reproductive health issues affecting USAID population programs. The break out groups examined key issues associated with individual topics and offered recommendations for USAID and its partners.

Day 3 plenary sessions reviewed procurement and administrative changes, particularly as they affect program implementation. Small group discussions focused on these issues and others raised on Days 1 and 3, including administrative issues, how the changes in USAID might affect present programming, and actions needed to implement the recommendations brought forth during the meeting. The recommendations from the small group discussions were presented for response and discussion at a final panel session.

Immediate Results

Among the many achievements of the conference, a number of immediate results stand out:

- USAID renewed and reinforced its commitment to the issues of population and reproductive health.
- PHN officers felt they had been more fully engaged in discussions regarding the changes that are occurring in USAID.
- CAs and other participants gained a better understanding of both the opportunities and constraints USAID faces in the immediate future.
- The first steps were taken to advance the Agency's new population and reproductive health agenda. Numerous suggestions were made on how to expand existing population programs to include selected new reproductive health activities.

Follow-up Actions

In her closing remarks, Elizabeth Maguire reviewed the lessons learned from the meeting and outlined follow-up actions for the Office of Population to ensure that these lessons are communicated and implemented:

- Debrief senior USAID leadership on the major outcomes of the meeting.
- Prepare a brief report summarizing the major outcomes of the meeting, and distribute the report to all participants.
- Send a cable to all USAID Missions with a summary of the meeting.
- Share the major concerns and recommendations with the Agency's Working Group on Population and Health Implementation Guidelines, led by Nils Daulaire.
- Incorporate the major recommendations into new and existing working groups, i.e., the MAQ Working Group, the Joint Reproductive Health Task Force, the Adolescent Working Group, the Working Group on the Prevention of Unsafe Abortion, and the Gender Working Group.
- Establish an Administrative Working Group to address questions regarding USAID procurement, processes, and procedures.
- Consider joint planning and programming with the Office of Health and Nutrition on issues which cut across population, health, and nutrition.
- Request each functional division of the Office of Population to map out steps for follow-up with respect to their own portfolios and areas of responsibility.

SUMMARY OF KEY ISSUES AND RECOMMENDED ACTIONS

Following are key issues and recommended actions which emerged during the three-day Cooperating Agencies' Meeting and the PHN Officers meeting. USAID will refer to these observations in its efforts to move from dialogue to effective action.

Key Issue

PRIORITY OF POPULATION: Agency leadership needs to inform the population and health community about its decision regarding the use of population funds. This position is not clear to all elements of USAID/Washington nor to many Mission directors in particular.

Recommended Actions

- Disseminate the memorandum on the use of population funds via e-mail, cable, and USAID-wide notice as soon as possible.
- Emphasize the priority of population and the appropriate use of population funds in any discussions with Mission directors, the Program and Policy Coordination Bureau (PPC), and the Budget Office.

Key Issue

REORGANIZATION: Meeting participants voiced a strong sense of frustration and confusion about USAID's reorganization; which organizational unit(s) will have authority for final decisions in key areas such as budget allocations, technical staff assignments, and country-level technical strategy development and programming; and which organizational unit(s) will be accountable for the results USAID is aiming to achieve. Interim measures are needed to assure the continuation of program action while re-engineering measures are being finalized.

Recommended Actions

- Disseminate widely a complete organizational chart for the Agency. In the detailed description of the reorganization, define as clearly as possible and widely disseminate the following:
 - * Updates on the reorganization
 - * Roles, responsibilities, and authorities of the organizational units, particularly the Global Bureau and the regional bureaus, to key areas such as budgeting, technical staff assignments, country-level strategy development and review, and accounting for results
 - * Vertical and horizontal relationships among the organizational units
- Publish a "transition year plan" identifying interim measures which will assure continuation of program action while re-engineering is under way.

Key Issue **TECHNICAL LEADERSHIP AND STAFFING:** The number of PHN direct hire technical staff has declined significantly over the past five years while the sector budget has risen dramatically. In the face of some 22 PHN vacancies, the Agency mandate to improve accountability and achieve clear results may be seriously jeopardized.

Recommended Actions • Undertake streamlined recruitment of PHN officers, with priority on hiring from the pool of personal services contractors who are already familiar with USAID programs and procedures, and who have existing medical and security clearances which would permit expedited recruitment.

- Enhance advancement opportunities—including promotion, choice assignments, and training—for PHN officers to prevent continued loss of experienced officers to other backstops that appear to have clearer advancement opportunities.
- Make Agency PHN staffing levels proportional to the sector's share of Agency resources.
- Set workforce planning objectives and time lines for achieving objectives.

Key Issue **PROGRAM DESIGN AND IMPLEMENTATION:** The role of the Global program in Agency organizational changes, program design, procurement, and implementation is not well understood. Worldwide programs differ from Mission bilateral programs but must be linked to and complement Mission programs.

Recommended Actions Involve Global Bureau staff in the re-engineering working groups formed to operationalize reforms so that Global efforts are integral to the Agency program and supportive of bilateral programs.

Key Issue **PROCUREMENT:** Program implementation is seriously hampered by complex procurement requirements and the shortage of procurement personnel. This results in lengthy delays in critical procurement actions that cripple implementation. Although an 18-point procurement reform process is under way, it is unlikely to move fast enough to break through all current bottlenecks.

Recommended Actions • Establish an Administrative Working Group, with membership including USAID and the CAs, to focus on procurement reform.

- Direct the Office of Procurement to work with the Global Bureau to identify those aspects of administrative and technical management of contracts and cooperative agreements that can be handled without Office of Procurement approval, and transfer responsibility for these functions to Global technical staff.

- Use the PHN Center of Excellence as an experimental lab to implement the team approach by seconding procurement staff to the Global Bureau.
- Fill personnel vacancies.
- Develop transition plans to assure a smooth transition to new procedures.

Key Issue **BUDGET:** Budget authority for resource allocation remains unclear. The roles and responsibilities of PPC, the Global Bureau, and the regional bureaus need to be clarified.

Recommended Actions Clearly delineate budget authority and guidance, and reflect this in implementation guidelines issued by the Agency.

Key Issue **WORKING GROUPS:** PHN working groups may have overlapping functions, duplicate efforts, or overlook linkages.

Recommended Actions

- Review the tasks of present population, health, and nutrition working groups to determine linkages, combinations, and overlap, if any.
- Develop guiding principles for the structure and operation of working groups.
- Establish new working groups, e.g., Mission/country-level working groups and a group to define mechanisms and incentives for CA collaboration; expand and redefine present working groups as necessary.

Key Issue **PRIORITY COUNTRIES:** There are questions about the new priority country list and what will happen with non-priority countries, as well as “emphasis countries” for child survival, AIDS, and population activities. What relevance, if any, do these prior priority country lists have with regard to the allocation of resources?

Recommended Actions

- Widely disseminate the final priority country list. Make clear that this list will be a final, single list and will subsume the former sector-level lists.
- Build into the implementation guidelines budget guidance to ensure that human and financial resources relate to these priority countries.

Key Issue	<u>MISSION CLOSINGS:</u> Every effort should be made not to backslide and lose the investments USAID has made in close-out countries. Regional issues must be addressed in countries presently being “closed out.”
Recommended Actions	<ul style="list-style-type: none"> • Identify key regional issues and consider regional projects to address them. • Recruit local experts to strengthen indigenous regional institutions. Compile, in conjunction with Missions and regional bureau staff, information on regional organizations and their areas of expertise, capacity, and reputation. • Establish a working group at the Center level to develop guidelines for supporting viable institutions. • In close-out countries, Missions should assess donors and identify those that can assume responsibility for USAID-supported activities. Establish mechanisms for transferring responsibility. • Direct POPTECH to compile a census of regional organizations, their areas of expertise, capacity, and reputations. • Educate donors about CA expertise available to spur continued work in close-out countries.

Key Issue	<u>EXPANDING INTERVENTIONS:</u> There is still some confusion about the definition of reproductive health and the nature of USAID’s planned investments in reproductive health areas. Operations research is needed to assess the cost-effectiveness and impact of integrating and linking reproductive health interventions with family planning services and approaches to information and service delivery.
Recommended Actions	<ul style="list-style-type: none"> • Further clarify the goals and inter-relationships of reproductive health, abortion, quality of care, sustainability, female education, and women’s empowerment. • Widely disseminate guidance on proposed investments in reproductive health. • Better evaluation indicators that measure progress in the new directions/interventions need to be developed and implemented. • Commit appropriate levels of funding for program evaluation activities. • Prepare a list of priority operations research issues and topics related to reproductive health and family planning. • Support CA efforts with regard to adolescents and post-abortion activities.

Key Issue **COUNTRY STRATEGIES:** Country working groups should be set up in Missions and USAID/Washington and should include host country representatives, NGOs, donors, and CAs.

- Recommended Actions**
- PPC should recommend the creation of Mission/country-level and USAID/Washington working groups, both for strategy development and implementation.
 - Ensure that strategies are developed using a participatory process.
 - Country specialists in the Global Bureau should ensure that these working groups continue to function throughout the program implementation period.
 - Streamline the process of approving country strategies to effectively delegate authority to the field.

Key Issue **CA AND DONOR COORDINATION:** USAID should urge closer collaboration among CAs and develop incentives and rewards for CAs to work closely together, particularly in close-out countries. Donors can benefit from CA expertise in the field.

- Recommended Actions**
- Establish a Center-level working group to deal with CA issues, including the development of criteria for collaboration; ensure collaboration mechanisms are built into new project designs.
 - Global Bureau and PPC donor coordination units and Mission staff should educate donors regarding CA expertise and encourage donors to draw on CA knowledge and experience on assessment visits and projects in close-out countries.
 - Disseminate information regarding CAs' use of core funding to participate in other donors' design activities.

Key Issue **BUY AMERICA:** For sustainability and effective program implementation, USAID must look at Buy America restrictions, particularly for hiring third country nationals and using host country institutions. USAID needs to encourage heavier reliance on local capacity and remove barriers to this increased reliance.

- Recommended Actions**
- Re-examine USAID's Buy America policy to make it less restrictive and more applicable to sustainable development, with special attention to use of host-country consultants and procurement of pharmaceuticals.
 - Draft a blanket waiver for right-hand drive vehicles, particularly in Africa and Asia.

Key Issue

ABORTION: Regardless of the legal status of abortion, women in all societies undergo unsafe abortions, with very high abortion-related mortality and at tremendous cost to women's health. Virtually every speaker addressing reproductive health at the meeting strongly urged USAID to take definitive steps to address this enormous problem and take the lead in helping to decrease unnecessary mortality due to botched abortions.

Recommended Actions

The Agency should fund abortion-related activities to the fullest extent possible under the law and authorize USAID-funded family planning programs to provide post-abortion family planning services and treatment of abortion complications where appropriate and needed.

BREAK OUT GROUP SUMMARIES

Under the new Agency strategy for population and health, the Office of Population will seek to expand family planning programs to include key reproductive health interventions. During Day 2 of the 1994 Meeting of Cooperating Agencies, 18 break out groups examined family planning and reproductive health issues that may form part of USAID population programs in the years ahead.

The break out groups were led by panels of experts and dealt with the family planning and reproductive health issues in greater depth than the plenary sessions. Each group discussed the key issues associated with individual topics and offered recommendations for follow-up by USAID/Washington, USAID Missions, and the Cooperating Agencies. The Office of Population will look closely at these ideas and recommendations to further develop plans of action and future program activities.

Following are summaries of the 18 break out group discussions, including the key issues and recommended actions identified by those groups.

1

MAXIMIZING ACCESS AND QUALITY OF CARE (MAQ)

Key Issues

The population and health community has a great deal of experience in defining and implementing quality of care as a factor in service delivery programs. A conceptual framework establishing six quality of care program elements was developed by Bruce and Jain. Indicators to assess quality and methodologies to improve quality are available. USAID is working to better understand and address MAQ issues from the user's perspective. Service guidelines are being assessed and updated as part of USAID's Medical Barriers Initiative.

Experience indicates that MAQ efforts are best directed at the service delivery level. Host governments are increasingly knowledgeable about the importance of quality of care.

Key challenges to MAQ include the need to

- Consider the user's perspective.
- Involve providers in identifying problems and solutions.
- Link training and supervision to quality of care, both to ensure provider competence and reflect user needs.
- Link pre-service training curricula and in-service guidelines.
- Address the duality and "creative tension" that exist between quantity and quality in programming. Recognize that MAQ results may need time to emerge.
- Address the need for data, both qualitative and quantitative, at different program levels.
- Set priorities for use of USAID resources.
- Update and widely disseminate MAQ lessons learned.

The above challenges and issues need to be operationalized, and a sufficient time line should be formulated to achieve quality of care results.

Recommended Actions

Cooperating Agencies:

- Participate on the MAQ Task Force/Steering Committee recommended to be established by USAID.
- Coordinate efforts to disseminate information, including lessons learned, about successes and failures of ongoing MAQ efforts.
- Participate in the planned 1995 EVALUATION Conference on MAQ field experience. Focus on testing quality indicators and gathering empirical evidence of impact.
- Empower clients to change the dynamics of client-provider interaction.

- Review DHS questionnaires and other data sources to ensure that MAQ issues are adequately addressed.
- Review and update information provided to clients regarding side effects.
- Improve the supervision of service providers to ensure MAQ.
- Establish training **sites**. Do not just train individuals.
- Use women's groups as vehicles for implementing the IEC and counseling aspects of quality (outside of family planning programs) and to emphasize the user's perspective.
- Conduct follow-up studies on contraceptive drop-outs (regional and worldwide).

USAID/Washington:

- Establish an MAQ Task Force/Steering Committee to provide guidance to shape the MAQ process and address the following priorities:
 - * Develop diagnosis/assessment tools to assess both client and provider knowledge, thought processes, and actions. Include client follow-up studies.
 - * Develop tools to improve MAQ.
 - * Address MAQ measurement and evaluation issues.
 - * Formulate a dissemination strategy for MAQ interventions.
- Sensitize USAID Mission PHN officers to the importance of quality as a means to increase program impact.
- Disseminate impact data to USAID Missions.
- Incorporate quality indicators (e.g., continuation rates and discontinuation rates) as evaluation factors in contracts and cooperative agreements.

USAID/Missions:

- Delegate self-selected USAID staff to participate on the MAQ Task Force/Steering Committee through the use of electronic mail, participation in field follow-up visits, and the creation of linkages with CA efforts related to MAQ.
- Sensitize policy-makers and program implementors to the importance of quality as a means to increase family planning/health program impact.

2

DMPA: WHAT NEXT?

Key Issues

The CA community, USAID, and other donor agencies, such as WHO, have considerable experience with injectable contraceptive use. The main problem for USAID is supply. USAID does not presently provide the commodity, and, even if a contract for provision were secured immediately, supply of DMPA would take at least six months to reach the field. Problems with logistics and supply stock-outs have also been documented in numerous case studies, for example in Peru and Bangladesh.

The CAs are poised to conduct research on and provide training, IEC, and service delivery for DMPA use. USAID Missions are anxious to obtain the commodity and are frustrated with the lengthy process. Discussions are seriously constrained by the supply problem, thus impeding further progress toward programmatic recommendations.

In reference to demand, counseling for the end-user is the key to success and continuation. A persistent issue is how to ensure safe needle/syringe use. The uniject method is desired, but it is a long-term solution, not viable in the short run.

Recommended Actions

Cooperating Agencies:

- Continue developmental work to pave the way for the introduction and expansion of DMPA once supplies are available.
- Coordinate with other donors to identify and distribute interim supply.
- Work with individual USAID Missions and USAID/Washington to develop specific in-country strategies.

USAID/Washington:

- Secure the commodity. If a contract is not signed with UpJohn shortly, take an active role in coordinating DMPA supplies with other donors.
- Keep CAs and USAID Missions informed regarding procurement status/schedule.
- Respond to USAID Mission requests for technical assistance.

USAID/Missions:

- Continue with planning specific country strategies, taking care not to create demand if there is no scope for providing commodities.
- Seek advice from local groups, CAs working in-country, and USAID/Washington regarding program implementation.
- Prepare for the introduction of DMPA by executing the necessary groundwork, especially coordinating with Ministries of Health, local women's groups, and other local health advocates, to secure regulatory approval and generate a positive public image of DMPA.

3

NORPLANT® IMPLANTS

Key Issues

NORPLANT® implants is possibly the most-documented contraceptive method in terms of biomedical effects, usage, and programmatic implications. This extensive literature facilitates an in-depth discussion of lessons learned and strategies for future action.

As of 1993, 28 countries had registered NORPLANT® implants with their regulatory authorities. Fifty-five countries have product introduction experience. Worldwide, 2.4 million women have used NORPLANT® implants, the majority of whom—1.5 million—are in Indonesia.

Key issues in program implementation include the following:

- Unit cost and program cost must be considered. When comparing NORPLANT® implants to other methods, NORPLANT® implants' average use-life of 3.5 years can be an advantage. Direct costs may be difficult to determine, and abstract costs, such as the opportunity cost the user assumes by using different methods, should be addressed. Additional cost issues include a need for both insertion and removal procedures and information systems for client counseling and follow-up. Would a lower price increase usage? Currently, high costs have resulted in uneven stock availability and limited access to the method.
- Attention to the user's perspective is imperative for quality programming. Potential users must be informed of side effects.
- Criteria need to be developed for further selection of countries appropriate for NORPLANT® implants introduction and service expansion, including appropriate infrastructure, economic status, and likely demand. *There should be a formal assessment of these parameters before NORPLANT® programs are allowed to expand.*
- In quality programs, demand is high and often exceeds supply. Access is constrained by cost. Donors must therefore be prepared to provide substantial commodity assistance.

USAID and its partners must prioritize where support for introduction and expansion strategies should occur. For example, is NORPLANT® implants provision appropriate in countries where USAID is planning Mission closings? This depends on a close examination of the issues outlined above. USAID must help in any way possible to lower unit cost. Continuous supervision and retraining should occur at all service delivery sites.

USAID, through its CAs, should improve information provision to potential users. At a minimum, users should understand the duration of

action, procedures for removal, expectations regarding side effects, and, if appropriate, the product's mechanism of action. It should be emphasized to the client that the implants may be removed upon demand at any time for any reason.

Women's groups and other interested parties should be involved in planning NORPLANT[®] implants introduction and expansion. Dialogue with other donors should continue to ensure adequate provision of the commodity.

Recommended Actions

Cooperating Agencies:

- Work with USAID to develop priority country lists for NORPLANT[®] implants introduction and expansion.
- Reiterate the importance of a careful, phased, sequenced introduction and expansion strategy, possibly by developing a checklist for managers.
- Address the shared division of labor/responsibilities for follow-up and/or removal by providers and users.
- Research the programmatic impact of NORPLANT[®] implants (i.e., method switching, effect on quality of family planning services) for both introduction and expansion.
- Ensure in-country capacity for NORPLANT[®] implants insertion and removal, including training.

USAID/Washington:

- Address the cost issue. Compare unit prices and re-examine both service delivery and client costs.
- Explore the role of additional donors as potential suppliers of commodities, and utilize USAID funds to ensure program quality (including training, etc.).
- Actively pursue alternatives, such as NORPLANT[®] II and generic implants.
- Develop priority country lists for introduction and expansion activities.
- Emphasize the need for quality of care in NORPLANT[®] implants introduction and expansion strategies. Remember that a poor quality NORPLANT[®] implants introduction may damage an entire family planning program.

USAID/Missions:

- Ensure appropriate planning for and monitoring of NORPLANT[®] programs.

4

OPPORTUNITIES AND ISSUES IN POSTPARTUM FAMILY PLANNING SERVICES

Key Issues

The integration of family planning services and postpartum care is a cost-effective way to provide widespread, high-quality services to high-risk groups. Effective integration requires services which promote informed choice and offer high-quality care, a broad mix of methods (no method-specific programs, such as only a postpartum IUD program), and sensitivity to the clients' preferences. Integrated services should be offered at flexible access times and not offered solely during labor or with post-abortion programs.

Managers of successful postpartum family planning programs recognize that specific targets undermine full client choice. Programs may be integrated into maternal and child health (MCH) programs, for example, offering family planning counseling during prenatal visits, and incorporated into community-level programs, such as outreach to assist non-hospital births. Other priorities for postpartum programs include training and counseling, ensuring sufficient budget resources, securing supplies for high-risk groups, especially rural populations, and providing the lactational amenorrhea method (LAM) as a method of family planning. In particular, if women are breastfeeding, pill use should be limited to progestin-only pills.

Recommended Actions

Cooperating Agencies:

- Develop **high-quality** postpartum programs.
- Make a range of family planning methods available throughout the pregnancy and postpartum period.
- Improve linkages and referral to other MCH and reproductive health programs.

USAID/Washington:

- Establish quality guidelines for postpartum initiatives.
- Include postpartum services in insurance coverage.
- Encourage private sector involvement.

USAID/Missions:

- Promote quality postpartum programs with host government agencies.

5

POST-ABORTION CARE

Key Issues

USAID's new population and health strategy seeks to cut maternal mortality in half by the end of the decade and promote women's reproductive health. Unsafe abortion is a leading cause of maternal mortality. Recent surveys conducted by The Population Council in several African and Latin American countries show a large percentage of unwanted pregnancies, a significant percentage of which end in abortion. USAID and its partners must focus renewed attention on unsafe abortion.

Numerous problems are associated with unsafe abortion. Many women undergoing unsafe abortions are adolescents, non-users of contraception, or individuals who induce abortions themselves or seek abortions from providers with no medical training. Unsafe abortions are costly to health systems and account for a large proportion of emergency beds in medical care facilities.

The service structure of health systems poses a dilemma to women seeking emergency care. Health care systems are often ill-equipped to respond to emergency abortion needs; treatment is centralized; and providers may have negative attitudes toward patients. Emergency treatment may solve immediate problems, but it does little to prevent the recurrence of unintended pregnancy. Treatment is not linked to family planning nor to regular maternal health care systems. The systems work at different sites with different hours and maintain weak referral systems.

Measures to prevent unsafe abortion are impeded by the following:

- Clients' lack of knowledge about and access to appropriate contraceptive methods (i.e., barrier methods), especially for adolescents.
- Lack of funding for training and equipment to improve post-abortion care.
- Poor organization of service delivery systems. Family planning services are separated from abortion or post-abortion services.
- Provider motivation, attitudes, and training. Providers are not adequately trained in both contraception and post-abortion care. They are not able to provide guidance regarding appropriate contraceptive methods to post-abortion clients. Financial incentives favor providing abortions rather than contraception.
- National policies and attitudes and donor policies which discourage comprehensive approaches to abortion issues.

All of the elements of post-abortion care must be defined, disseminated, and instituted in health care systems. These elements include

emergency treatment services at all levels of health care systems complete with training, treatment protocols, and equipment and creation of linkages between emergency services and comprehensive reproductive health services. USAID should avoid self-censorship and promote awareness of the issues at the policy-maker level. Emphasis should be on post-abortion care as **life-saving** care. Further research, including the incorporation of appropriate abortion questions into DHS, should be promoted.

Recommended Actions

Cooperating Agencies:

- Educate staff about unsafe abortion and measures to prevent it.
- Participate in an informal consortium of CAs and other partners already working in the area of unsafe abortion.
- Develop initiatives appropriate to each CA's functions and resources.

USAID/Washington:

- Convene a working group on the prevention of unsafe abortion.
- Consider organizing a meeting of CAs on the topic.
- Develop clear guidance for CAs on the desired next steps.

USAID/Missions:

- Educate staff about the issues and situations in host countries.
- Inform staff about existing laws and regulations governing activities in the area of post-abortion care.

6

INCREASING INVOLVEMENT OF MEN IN FAMILY PLANNING

Key Issues

The involvement of men in family planning programs and services is a neglected area. Historically, methods used to regulate fertility were controlled by men, but with the advent of modern contraceptives, the burden of fertility regulation shifted to women. At present, methods and services in most countries are overwhelmingly oriented toward women, and men have become marginalized from family planning programs.

There is a compelling need to focus more attention and resources on men's involvement in family planning. Below are reasons favoring increased attention to the role that men play:

- Men exercise considerable power over fertility decisions, but their role as potential supporters of women's reproductive health and the decision to use contraceptives has been underestimated.
- Women's health advocacy groups are asking why women should bear most of the responsibility for contraceptive use. Why is there not more focus on methods for men?
- Men represent a relatively untapped market for family planning services. In the few areas where services for men have been provided, men have used them.
- The HIV/AIDS crisis underscores the importance of responsible sex practices on the part of both men and women. Only the condom is known to be effective against HIV and other STDs.
- No-scalpel vasectomy is easier, safer, and less expensive than sterilization for women. Successful introduction of vasectomy in some countries has demonstrated the acceptability of this method when information, education, and services are directed toward men.

Surveys and operations research from various countries have consistently found that there is demand for male contraception and that men **and** women lack information and have misconceptions about male methods. Men express interest in their partners' health and reproductive decisions; however, there is evidence of inadequate spousal communication. Surveys show that talking to another male contraceptive, good communication between partners, and knowledge of contraception are all associated with men's increased participation in family planning decisions. Research also finds that well-designed and targeted IEC programs work. In some countries, almost any reasonably designed program intervention directed toward men has resulted in the increased participation of men.

The principal obstacles, therefore, appear to be the lack of attention to and resources for increasing men's involvement in family planning. A

first step to increase men's participation should be to improve awareness and sensitivity among the professional family planning community.

Men's involvement in family planning programs is not limited to their increased use of vasectomy or condoms. Equally important is increasing men's support for women's contraceptive and reproductive health decisions, enhancing their sensitivity to gender-related concerns, and improving safe sex practices.

Contraceptive choices for men are lacking, and more research is needed to expand the number of male contraceptive methods.

Recommended Actions

USAID:

- Devote more resources to conduct research for additional, improved contraceptive methods for men, particularly new barrier and reversible methods.

USAID and Cooperating Agencies:

- Devote more attention and resources to survey and operations research in order to accomplish the following:
 - * Determine directly from men what they know about their partner's reproductive health. Find out what men want in terms of services and what enters into their decision-making processes.
 - * Determine women's attitudes and learn more about spousal/partner communications.
 - * Implement pilot projects to test new program and IEC approaches.
 - * Develop programmatic indicators to monitor men's involvement and evaluate performance.
 - * Document and disseminate lessons learned from both successful and unsuccessful programs.
- Design programs that pay attention to men as well as women. Avoid repeating the conventional, but mistaken, wisdom that men are the problem. Tailor services to meet men's needs.
- Donor agencies, CAs, and host-country institutions should
 - * Improve awareness.
 - * Support policy development.
 - * Develop available and accessible services and IEC directed toward men.
 - * Promote research.

7

BUILDING SUSTAINABILITY IN FAMILY PLANNING PROGRAMS

Key Issues

A number of CAs have learned important lessons from their involvement in developing sustainable approaches to family planning programs. Some keys to success include the following:

- Institutional commitment and strong program leadership.
- A client-oriented approach to providing services.
- Use of creative financing strategies, such as diversification of services and cross-subsidies.
- Ability to use data, especially on program costs, to make management decisions.

USAID plays an important role in the design and monitoring of projects, but may not be giving consistent messages about sustainability, i.e., what should be pursued, how far donors should go, and so on. Other challenges to building sustainability include

- Sustainability objectives must balance with satisfying unmet need among the poorest populations.
- Many organizations are ill-prepared for sustainability.
- Sustainability is more than financial.
- Some program aspects, such as training, may continue to require subsidies.
- The private sector should be involved early in program development.

USAID and its CAs need to develop a strategy to maximize the utilization of both public and private sector resources. Under such a holistic approach, the private sector role should be maximized, thus allowing the public sector to target the neediest populations. In some countries the public sector may be the primary service provider, while in others the appropriate role is to “fill in the gaps.” Program managers should ensure that public sector resources are directed through the most efficient entities.

Recommended Actions

Cooperating Agencies:

- Support professional exchanges and observational visits by representatives of organizations pursuing sustainability strategies.
- Encourage NGOs to serve as subcontractors to governments.
- Train private sector partners to increase their involvement in family planning.

USAID:

- Combine flexibility with a serious message about sustainability.
- Include explicit discussion of sustainability in project papers and requests for proposals (RFPs).
- Increase policy dialogue with governments.
- Seek to exempt NGOs from legislative restrictions, such as the Brooke and Pressler Amendments.
- Avoid arbitrary scheduling of program phase-outs.
- Work with financial institutions so grantees can effect gradual transitions from grants to loans.
- Be proactive in resource development issues.

8

FOCUSING ON RESULTS—EVALUATION

Key Issues

Historically, USAID has been at the forefront in recognizing the important role of evaluation in program management and oversight. Compared to evaluation efforts in other development sectors, evaluation in the population field is very advanced, particularly in aiding understanding of how programs work, the development of reliable indicators, and the collection and analysis of data.

To date, however, evaluation has focused more on monitoring than on impact. USAID project evaluations have been process evaluations, while impact evaluations have been uneven in quality, non-empirical, and frequently lacking in rigor. In the past, USAID, as well as other donors, has not exhibited the level of commitment needed to strengthen impact evaluation in a way that assures definitive and defensible results. Rigorous methods to assess impact are available; the data, however, are not.

The price of a weak evaluation effort is the continuation of what may be ineffective strategies of assistance—a situation that reduces overall cost-effectiveness.

Key evaluation issues to be addressed include the following:

- Consensus is needed on a definition of what constitutes impact evaluation (design, content, and conduct).
- Concern persists about the utility of impact evaluation.
- There is concern about the degree of commitment—or lack thereof—of program managers to using evaluation results.
- Useful formats and approaches for the dissemination of evaluation results are needed.
- Indicators should be broadened to include reproductive health and other new priorities.
- Some USAID Missions resist rigorous evaluation designs because of their cost, the diversion of potential program resources, and a perception that such evaluations have limited usefulness for Mission program management purposes.

USAID and its partners should take a number of steps to strengthen the evaluation process:

- Develop indicators for reproductive health, adolescent health, and other outcomes.
- Focus indicators on individual outcomes, such as the prevention of unwanted births, rather than just TFR.

- Increase efforts to collect data on programs, particularly from service delivery points.
- Strengthen USAID's evaluation ethos.

An examination of evaluation efforts in the U.S. domestic family planning program is recommended.

Recommended Actions

Cooperating Agencies:

- Coordinate their monitoring of efforts.
- Use results from monitoring to help generate questions for impact evaluation.
- Involve host country staff in the design and implementation of evaluations.
- Seek opportunities to employ experimental designs for impact evaluation.
- Promote the dissemination of evaluation results.

USAID/Washington:

- Develop tools to measure the demographic effects of other interventions, e.g., reproductive health and education.
- Establish consistent definitions for new indicators.
- Encourage greater use of panel studies.
- Reach a consensus on appropriate purpose-level indicators for central projects that include reproductive health and other new priorities.
- Promote the dissemination of evaluation results.
- Commit adequate resources for evaluation (including collection of appropriate data) within funding of central projects.

USAID/Missions:

- Reach a consensus on appropriate purpose-level indicators for country programs.
- Evaluate at the project purpose level as well as output level.
- Involve host country counterparts in evaluation activities (at both design and implementation levels) to promote sustainability of evaluation as a management tool.
- Facilitate the use of evaluation results by program managers.
- Commit sufficient resources for program evaluations.

9

GENDER PLANNING IN POPULATION: STRATEGIES FOR IMPLEMENTATION

Key Issues

Gender affects how individuals see themselves, each other, the institutions in which they work, and the programs they design and support. Gender is an endeavor that is unsettling and even threatening to many people. Therefore, gender issues must be addressed on a recurrent basis until internalization and institutionalization promote automatic consideration. This will ultimately enable positive impact on and change in the everyday lives of the people USAID's programs seek to benefit.

Sex is not synonymous with gender, which refers to the cultural meanings people attach to biological differences. Family planning programs' focus on women is not coterminous with gender sensitivity. Nor is a focus on contraceptive technology a means of moving women into the paid workforce. When addressing gender issues, the Gender Planning Methodology of Moser (1989) has been described as a useful tool. It examines women's and men's relative roles in reproduction, production, and community management and politics, helping to identify both practical and strategic gender needs.

In order to make significant inroads in this area, gender issues need a long-term, high-priority commitment from organizations, assigned staff from both sexes, recurrent training and awareness raising, and integration into all aspects of programming. Gender cannot be considered as an add-on type of analysis. A key challenge is to gain legitimacy for gender within organizations, as well as to balance a command-driven mandate to consider gender with the need for a certain amount of autonomy among the field organizations USAID supports.

A key challenge for each individual is to examine his or her own gender biases as well as looking for them in others.

Recommended Actions

Cooperating Agencies:

- Train staff for gender awareness and sensitivity.
- Make gender a high priority and assign responsible staff (male and female) to implement gender policies.
- Interact with other agencies on gender issues.

USAID/Washington:

- Train and retrain staff for gender awareness and sensitivity.
- Create a CA working group to encourage interaction between USAID and the CAs and interaction among the CAs on gender issues.
- Begin to assemble training materials that have been created by the CAs on gender issues and training.
- Provide guidance for USAID Missions.

• ***USAID/Missions:***

- Train and retrain staff for gender awareness and sensitivity.
- Encourage analysis of gender considerations within the specific cultural context of the host country.
- Feed information back to USAID/Washington from analyses, research, case studies, and lessons learned.

10

REPRODUCTIVE HEALTH FOR ADOLESCENTS

Key Issues

Although it is a politically, culturally, and socially sensitive subject, adolescent reproductive health must be addressed in view of increasing adolescent sexual activity, unwed adolescent pregnancy, and the incidence of STDs and HIV/AIDS.

Adolescents differ from adults: they are younger, less likely to be married, face conflicting societal values/pressures surrounding sex, participate in sex less frequently and with less planning, and face greater barriers to receiving family planning services. Efforts to address adolescent reproductive health must take these special needs into consideration.

Other subjects which also warrant greater attention in the area of adolescent reproductive health include the needs of unmarried women, gender issues, the powerlessness of young women, male involvement, and sexuality.

Programmatic concerns include the need to

- Make choices between integrated or specialized services and community outreach vs. center-based programs. MEXFAM has had success, not with special youth centers, but with outreach to schools, recreational areas, and gang meetings.
- Consider the respective roles of education and service delivery.
- Work with limited resources.
- Involve adolescents in every aspect of the program process, including design, implementation, and evaluation.
- Build on existing environments and initiate programs in hostile political environments.
- Gain the trust of adolescents and ensure confidentiality for reproductive health service programs.
- Reinforce clear and appropriate values and norms.

Programs should promote proven outcomes such as delayed initiation of intercourse, increased contraceptive prevalence, and decrease in unprotected sex.

To date, there has been no systematic evaluation of adolescent reproductive health programs nor have the results of existing projects been effectively disseminated.

**Recommended
Actions*****Cooperating Agencies:***

- Spotlight projects that are already under way, even if they have not been formally evaluated.
- Promote collaboration between the public and private sectors.
- Train providers in adolescent counseling.

USAID/Washington:

- Identify impact indicators for adolescent reproductive health programs.
- Do not wait for evaluation results before proceeding with pilot programs. Disseminate lessons learned from existing projects.
- Promote collaboration between the public and private sectors.
- Gather data on adolescents and include inquiries into adolescent health and reproductive issues in DHS questionnaires.
- Earmark funds for adolescent programs.
- Support broader collaboration and networking among various sectors (health/family planning service delivery, education, HIV/STD prevention, etc.).
- Promote a broader method mix for adolescents.
- Strengthen quality of care.

USAID/Missions:

- Collaborate with NGOs to support their existing adolescent programs and work to expand them.
- Promote collaboration between the public and private sectors.

11

ADDRESSING THE PREVENTION OF HIV/STDs IN FAMILY PLANNING PROGRAMS

Key Issues

There is limited information available on the issue of addressing HIV/STDs within family planning programs, and what is known is not widely circulated. Relevant facts include the following:

- Condoms prevent HIV/STDs, but not 100% of the time.
- Reducing the number of sexual partners helps to reduce the transmission of HIV.
- Behavioral change concerning sexual practices (e.g., condom use and reduction in the number of partners) is difficult.
- Prevention of STDs helps to prevent HIV transmission.

The prevention of HIV/STDs is a complex issue, and there are a number of diverse perspectives on how to deal with it. A consensus has not yet been reached in the public health community regarding the most cost-effective interventions for HIV prevention. Many feel that treatment of HIV/STDs is the answer. Others stress HIV/STD prevention. With few resources, the treatment of HIV/STDs is very expensive and difficult—and in some situations impossible—to undertake effectively.

More discussion is needed on the appropriate role of HIV/STD activities within family planning programs. Guidelines are needed, as is more research to assess the feasibility of different interventions. Existing expertise and information related to addressing HIV/STDs should be disseminated.

Recommended Actions

A working group will be formed with appropriate members from the CAs, USAID regional bureaus, and the Global Bureau. Several individuals have volunteered or been identified to be members of this working group. The Global Bureau will coordinate the formation of this working group and will convene an initial meeting by May 1994. The working group will outline the agenda for addressing key issues during the next six to 12 months.

Recommendations for the Working Group:

- A major meeting, “Addressing HIV/STDs within Family Planning Programs,” should be arranged for the CAs and USAID. This meeting would provide ample time to fully examine the complexity of problems and issues. CAs would make presentations of current work in the area of HIV/STD interventions within family planning programs. USAID guidelines for addressing HIV/STDs within family planning programs

would be discussed fully and a consensus reached regarding specific program interventions.

- A research agenda should be proposed. A number of pilot projects should be implemented to test various approaches. A group of HIV/STD/family planning program and research experts should meet and outline the research needed to address HIV/STDs within family planning programs. The Reproductive Health Survey of current HIV/STD efforts should be reviewed to gain data from already existing programs.

12

FEMALE CIRCUMCISION/ FEMALE GENITAL MUTILATION

Key Issues

USAID is taking a multi-sectoral and gender-based approach to the subject of female genital mutilation (FGM), expanding its focus beyond health and family planning and into areas such as democratization and human rights. For example, USAID's Office of Women in Development (WID) is raising awareness and encouraging USAID Missions to support indigenous groups' efforts to address FGM. WID is also providing support to the Inter-African Committee for its meeting in April 1994.

Numerous problems impede progress on this issue. These include cultural and religious beliefs and practices, attitudes toward reproductive health, including contraceptives and HIV/STDs, and the emphasis on short-term solutions.

FGM programs confront significant challenges. There is too much concentration on the health aspects of FGM and not enough on the sexual aspects. Programs need to target men and involve youths.

USAID and its CAs need to conduct operations research on FGM interventions, including IEC and health care delivery options. Concern for FGM should be incorporated into IEC programs and training for counseling and treatment of complications.

Recommended Actions

Cooperating Agencies:

- Incorporate attention to FGM into ongoing activities in family planning and reproductive health. For example, AVSC provides extensive training to service providers and could include familiarization with FGM. Do not establish new vertical programs.
- Build on areas of expertise in family planning to address FGM.

USAID/Washington:

- Convene a technical working group to review former or existing activities/programs to develop a comprehensive overview of successful and unsuccessful strategies.
- Review USAID activities more systematically to formulate a strategy for FGM in the context of reproductive health and other sectors.
- Consider proposals for new activities.
- Report the findings of this break out group to USAID's Population Sector Council.

USAID/Missions:

- Respond to initiatives from indigenous groups.
- Find ways to provide technical assistance to groups working with FGM.

13

SEXUALITY ISSUES FOR FAMILY PLANNING PROGRAMS

Key Issues

Family planning programs rarely address sexuality issues with contraceptive users including, e.g., how family planning methods may affect sexuality. These issues have a significant impact on contraceptive usage and continuation. Providers lack training in discussing sexuality issues, severely limiting candid discussion about sexuality. Clients often discontinue family planning because providers do not discuss sexuality issues.

Inclusion of sexuality concerns greatly improves the quality and relevance of family planning counseling. A number of models of sexuality education have been presented to promote positive, responsible behavior.

Recommended Actions

Cooperating Agencies:

- Increase training and service provider awareness about the importance of including discussions of sexuality issues as a means to improve client information and family planning continuation rates.

USAID:

- Support research to further identify the relationships between sexuality issues and continuation of family planning practice.
- Support research to identify the extent to which family planning providers discuss sexuality issues with clients.

14

BREASTFEEDING AND FAMILY PLANNING: PROVIDING BENEFITS FOR MOTHER, CHILD, AND FAMILY

Key Issues

Almost all women who breastfeed are candidates for family planning and reproductive health services. USAID should encourage breastfeeding and promote its use in conjunction with family planning.

Breastfeeding can interfere with contraception if women are concerned about the effects of specific contraceptives on the volume/value/safety of breastmilk and are not informed regarding such relationships. (Indeed, some forms of contraception can interfere with breastfeeding.) Moreover, declines in breastfeeding can offset increases in contraceptive use elsewhere in a population.

Despite these concerns, real progress in integrating breastfeeding and family planning has been slow. Breastfeeding and family planning **can** be synergistic, and women who use lactational amenorrhea for birth spacing are also likely to use contraceptives. More action is needed to capitalize on these factors.

Recommended Actions

Cooperating Agencies:

- Continue operations research on the synergy of breastfeeding and family planning.
- Examine training, supervision, and incentives for family planning workers to promote and support breastfeeding.

USAID/Washington:

- Continue to strengthen the knowledge base and promotion of breastfeeding in family planning.
- Continue emphasizing the integration of reproductive health and family planning programs.

USAID/Missions:

- Support the integration of breastfeeding in family planning training and supervision.

15

MATERNAL AND NEONATAL HEALTH AND NUTRITION

Key Issues

Small advances in maternal care can reap great benefits for mothers and newborns. A minimal package of clinical and public health services can ease the burden of death and poor health in poor countries. Beneficial interventions, such as iron folate distribution to women, are cost-effective and can be provided at the community level. The pivotal importance of midwives in the maternal care/family planning delivery system should be recognized. Midwives serve to link communities to the formal health care system; they can manage many of the obstetrical complications that kill women, and they can link women to referral facilities.

Maternal care should be integrated with family planning services. The challenge lies in determining a minimal package of services to be offered at each level within existing country infrastructures consistent with available resources. Services may be impeded by policies which prohibit the delegation of health care tasks and distort the allocation of resources. Training providers should integrate family planning and maternal care to manage both obstetrical complications and provide family planning services.

Recommended Actions

Cooperating Agencies and USAID/Washington:

- Conduct policy dialogue and provide assistance to develop cost-effective interactions between reproductive health and family planning activities.
- Identify interventions to address problems, such as anemia and the control and prevention of STDs, to include in a minimal package of services.

USAID/Missions:

- Start with a minimal package of interventions which includes maternal and neonatal health, nutrition, and family planning services. Ensure the package fits the existing infrastructure and resource availabilities, and add funding gradually.
- Train first- and second-level providers to provide maternal and family planning services.

16

LINKAGES OF FAMILY PLANNING WITH FEMALE LITERACY AND EDUCATION

Key Issues

There is a strong correlation between women's educational level and their use of health and family planning services. USAID's Offices of Population and Education are poised to take advantage of the opportunities this affords for synergistic programming. There is great expertise in both USAID offices, but coordinated efforts are infrequent. The Office of Education's new initiative for female education offers the opportunity to enlist interest groups that are already working with the Office of Population.

Female education and literacy are complex issues interrelated with other social problems, especially poverty. Key challenges to promoting linkages between family planning and female literacy and education include diminishing funds and the need to stimulate demand for education.

Policy improvement is the single most important direction USAID must take to promote female education and literacy. Indeed, appropriate policies are a prerequisite for all other development areas.

Recommended Actions

Cooperating Agencies:

- CAs involved with policy need to explore how their projects can promote more gender equity as a strategy for increasing demand for education and family planning.

USAID/Washington:

- Formulate an official statement endorsing a synergistic approach to population and education policy reform. This statement should be promulgated at international meetings, such as the 1994 International Conference on Population and Development in Cairo and the 1995 International Conference on Women in Beijing.

17

LINKAGES BETWEEN FAMILY PLANNING AND CHILD SURVIVAL PROGRAMS

Key Issues

Although conceptual and programmatic linkages between family planning and child survival programs have not been fully explored, evidence does suggest that mothers make joint decisions on family planning and child survival. Present experience shows that integrated programs can address both objectives effectively and efficiently and that vertical programs often contribute to fragmentation and lost opportunities. Separate funding and vertical programs create disincentives to integration, especially regarding program sustainability. However, in some weaker bureaucracies, only vertical programs may work.

Some environments are hostile to family planning and the only entry may be through child survival programs. Separate training programs discourage providers from offering both family planning and child survival services. For these reasons, the integration of programs should be encouraged where feasible. Also, the quality assurance approach should be utilized to focus attention on client and staff needs and expectations.

Recommended Actions

Cooperating Agencies:

- Develop a better understanding of the conceptual and operational linkages between family planning and child survival.

USAID/Washington:

- Set global target ratios between family planning and child survival funding. Provide funding to restore the appropriate balance between “child prevention” and “child support.”
- Apply ratios flexibly and encourage formal linkages between family planning and child survival.

USAID/Missions:

- Encourage family planning/child survival linkages and reduce vertical programs.
- Seek out PVOs that may promote the integration of services.

18

LINKAGES WITH ENVIRONMENTAL GROUPS AND PROGRAMS

Key Issues

Although some successful field projects linking family planning and local conservation efforts have been documented, the conservation/family planning link is not often apparent, and some authorities question whether bringing these two types of interventions together even makes sense. The divergent objectives and clients of family planning and environmental programs are not wholly conducive to integration: family planning programs target the individual, involve mostly women, and are short-term in nature. Environmental programs target community needs, involve and are staffed by men, and seek long-term benefits.

International environmental NGOs often shy away from family planning issues because of controversy and lack of information. Indigenous environmental groups in developing countries often view family planning programs as efforts to control the rural population.

Experience with integrated projects at the field level needs to be developed, documented, and disseminated. Where models of successful collaboration are demonstrated, funding mechanisms should be established. Projects should focus initially on rural areas where there is the greatest need and highest potential for collaboration. Projects should be designed around the needs of local people, and collaboration between local institutions is essential.

Policy formation is key to developing linkages between programs. USAID implementation policies, however, have not addressed either program linkage or integration. Promoting policies linking environmental and family planning programs may be more challenging than forging links at the local level.

Recommended Actions

Cooperating Agencies:

- The Futures Group and other CAs have heightened policy-makers' awareness of the environmental implications of high population densities and rapid population growth, highlighting the environmental advantages to investments in family planning. CAs should continue these important efforts in information dissemination.

USAID/Washington:

- Promote dialogue at the national and donor policy level to encourage the integration of environmental and family planning programs. Involve developing country NGOs in the process.
- Address environmental factors when formulating population policies and designing population programs. Consider the impact of demographic changes on natural resources and systems when developing environmental programs.

USAID/Missions:

- Facilitate integration of family planning and environmental projects.
- Identify projects at the national level and establish a working relationship with NGOs willing to experiment with conservation and family planning service delivery program linkages.
- Organize workshops among local family planning and environmental organizations to share concepts, promote linkages, and discuss methodologies to link projects.
- Encourage the formation of a model that explores the linkages between population, the environment, and economics.

APPENDICES

THE NEW USAID

THE HONORABLE J. BRIAN ATWOOD

This meeting is an outstanding example of what the new USAID is all about. This kind of participation and consulting is a tribute to the population and health community, outside the Agency and within. All of us owe a debt of gratitude to Ann Van Dusen, Duff Gillespie, Elizabeth Maguire, and their colleagues for their work on this meeting and on the issues that have brought us here.

We are pleased to have with us so many of you from our Cooperating Agencies—our closest partners in our technical assistance programs—as well as representatives of donor agencies and organizations concerned with population, women, health, and the environment. I am gratified that over fifty representatives from USAID's Missions have joined us as well. Their presence is but the latest evidence of the importance we attach to the challenge of population and development. For nearly three decades, we have worked with you. Together, we have made remarkable progress:

- Together, we have helped develop and introduce new contraceptive methods and thus given clients more choices and more control over their lives.
- Together, we have led the way in helping countries adopt innovative approaches to service delivery, including community-based distribution and social marketing.
- Together, we have supported large-scale training and communications programs.
- Together, we have helped countries build the capacity to plan and manage programs—programs, I would add, that respond to the needs of real people.
- Together, we have supported the collection of data on reproductive health in more than seventy countries. This has enabled governments, donors, and service providers to gain a reliable picture of attitudes and needs and thus improve our programs.
- And to make our efforts sustainable, we have tried together to be a model for the development community-at-large, showing what partnerships between government and private organizations can truly accomplish.

These are worthy achievements, but we cannot be complacent. Time is short. Demographers are giving us very frightening projections. A world of eight billion people is a certainty within the lifetime of our children. This fact is the driving force behind every challenge of development. Its social and economic implications, its environmental and political effects will confront American policy-makers for decades to come. That fact is as certain as the number itself. Everything we do as a development agency and as a development community certainly will be affected. How soon this number is reached and how much higher it may go is a challenge to us.

President Clinton and others in the administration—Vice President Gore, Tim Wirth, and I—understand that our first responsibility is to communicate to policy-makers, here and abroad, the consequences of these numbers; the consequences for political stability; the consequences for environmental change; the consequences for economic growth; the consequences for family and communities; the consequences, ultimately, for our planet and for human society as we know it.

Tragedy looms; its dimensions already apparent. It is the tragedy of human promise unfulfilled, as men and women continue to suffer lack of access to the information and means to prevent unintended births. It is the tragedy of women, adolescents, and children—forever ill, often dying—all from society's failure to make the small investments that enhance reproductive health, maternal

health, family health, and child survival. It is the tragedy of environmental degradation, poverty, and starvation, compounding each other. It is a tragedy where land and human institutions have failed to adapt to growing populations. Haiti and Somalia are only the most visible examples. The real tragedy is that we are likely to see more. If we would turn away—that would be the worst tragedy of all.

These problems are not—as some would put it—"other people's problems." We cannot escape their effect, and they demand policies that address root causes.

It is to this end that the administration has advanced "The Peace, Prosperity, and Democracy Act," a new charter for foreign assistance in the aftermath of the Cold War. It dovetails precisely with the strategy for development USAID has adopted. It sets forth a "diplomacy of prevention."

We have said that we will pursue a single goal—sustainable development—by addressing the five areas that determine whether development is sustainable or not: democracy, broad-based economic growth, the environment, humanitarian assistance and support for nations in transition, and, of course, population and health. Our work will be guided by a keen awareness of the interdependence of these issues.

Do corrupt and authoritarian governments care to provide health and family planning services that respond to the needs of the people? Can people work or children study if they are hungry or sick? Can democratic institutions survive where people are jobless and feel no sense of participation in their nation, their government, or their future? Is any development sustainable if women are not equal participants and beneficiaries?

These questions remind us that pursuing sustainable development will require integrated approaches. The Peace, Prosperity, and Democracy Act is designed to give us the tools to do just that. Once passed into law, the bill will establish programs that give people—particularly women, the great hidden factor in development—a sense of participation, ownership, and empowerment. The bill will not do **for people** in the developing world; it will help them do **for themselves**—building civil societies, acquiring skills and incomes, investing in human capital, unleashing their productive potential, and controlling their reproductive lives. There is nothing visionary in all this; it is just plain common sense.

Will we get the resources for this ambitious agenda? Although this administration is committed to reducing the deficit, it is also committed to our sustainable development objectives. Yet under the best budget scenario, we will have to do more with less. Every new idea, every proposed project, and every management reform will be assessed against this criterion.

This emphasis on results—what we can achieve with each additional dollar we invest—will extend to our new population and health strategy. It is a strategy driven by the sense of urgency we all feel. It aims for global impact. It incorporates the lessons of experience and the belief that all our programs must be participatory, involving from start to finish the people they are designed to benefit. Finally, it is a strategy that will demand ever-more integrated approaches to meeting our goals for population and health.

USAID's population and health strategy is built around four interrelated principles and objectives:

- Promoting the rights of couples and individuals to determine freely and responsibly the number and spacing of their children.
- Improving individual health, with special attention to the reproductive health needs of women and adolescents and the general health needs of infants and children.
- Reducing population growth rates to levels consistent with sustainable development.
- Making programs responsive and accountable to the end-user.

Under this strategy, support for family planning systems and services will continue to be the centerpiece of our efforts. It is far and away the most cost-effective intervention to help couples and individuals achieve their desired number of children and slow population growth. It has immediate benefits for the health and well-being of women, children, and families. It is especially critical to environmentally sustainable development.

The creation of a new Center for Population, Health, and Nutrition will encourage people working in these three areas to collaborate with one another. The new Center will enable us to find the synergies among these programs, especially in the complexities of reproductive health. It will enable us to explore linkages with programs in other sectors, reinforcing our population and health efforts.

In our policy dialogues with host countries and other donors, we will stress the interdependence among the goals of sustainable development. For example, we see long-term payoffs for both family planning and child survival accruing from support for the education of women and girls. We expect to step up our activities in this area and work with other donors that may have the capacity to do more.

An integrated approach to planning does not mean that we pile additional tasks on weak institutions or service providers. It does mean that we must avoid parochial attention to one set of goals at the expense of all others. To do otherwise guarantees that we will waste our limited resources and find ourselves on a sure path to failure.

Let me assure you, as I know this has been a subject of rumor and discussion, that we will stand by the commitments we have already made to increase funding for population, including family planning and related reproductive health programs.

In a time of fiscal constraint, population is one of the few areas of the USAID budget to experience a real increase in resources. In order to support both our traditional efforts in family planning and deal with the issue of population growth at its root causes and its immediate points of leverage, I have directed that a portion of additional population funds budgeted for Fiscal Year 1995 and onwards be available for a limited set of innovative activities. These will include the female education and empowerment programs to which I referred earlier. They will be specifically designed to enhance the demand for and use of family planning services in the near term. The funds provided for these innovative activities would be **in addition** to general funding for female education and empowerment programs under the Development Assistance Fund.

This is a new and promising approach for us. We will closely monitor requests for these kinds of uses and monitor their impact as well.

While I am deeply committed to augmenting our existing programs, I am equally committed to USAID's leadership role in family planning. We have a strong comparative advantage in this area, and we will not diminish the proportion of our assistance that we devote to family planning.

There is another point on which there should be no misunderstanding. To speak of our aspiration for integrated approaches is not to impose a universal prescription for how family planning systems should operate or how services should be delivered at the grassroots level. That would fly in the face of all we have learned about what works in family planning and reproductive health. We must avoid what one of our colleagues has called the "Swiss army knife" approach to services: trying to do everything and doing nothing well. My apologies to the Swiss!

Some people are concerned that a more integrated approach to population, health, and nutrition will make it more difficult to hold programs accountable for results in any one of these areas. The new results-oriented USAID will look closely at what we have achieved on indicators like contraceptive use, fertility decline, and maternal and infant mortality, and we will continue to seek better measures of the impact of our programs. In addition, we will not neglect the more difficult questions: Are programs responding to the needs of users? What are the links between the interventions we support and changes in family planning and health status? Finally, have we helped put in place systems that are sustainable and that will yield results not only this year but five, 10, and 15 years hence?

This last criterion is particularly important. There is a growing list of countries where USAID has made a major contribution to progress in family planning and health, among them Mexico, Jamaica, Bangladesh, Indonesia, Morocco, Egypt, Kenya, and Zimbabwe. Colombia will soon join the list of graduate countries that now includes Thailand, Tunisia, and Korea. These results were the result of sustained involvement over a period of years—and the patient efforts of USAID Cooperating Agencies.

As we plan for results, let us keep foremost in our minds the perspectives of the individuals who are the users of family planning and health services. We have long been committed to the goals of improved quality of care and increased access. We must do more to consult with clients about which barriers to these goals loom largest **for them**.

In addition to the mothers and children who are the core clientele of the programs we assist, we must pay attention to the needs of adolescents, men, unmarried women, and young couples without children. We will need to help the organizations we assist find better ways to reach out to them, whether through schools or bars or recreation centers or gathering places. We must do more to use the power of mass media to communicate ideas and information.

We face additional challenges in responding to the needs of women. Attention to gender roles is fundamental to the success of programs we assist. We must support the full participation of women at all levels of family planning and, indeed, in all health and development programs. We must help women overcome the obstacles they face in obtaining services or using different contraceptive methods. We must see that programs are designed to benefit women. And, we must help programs strengthen men's support and participation.

At this meeting, I expect you will address further the linkages between family planning and other dimensions of reproductive health. In settings where women continue to die due to pregnancy and

childbirth, where HIV/AIDS and other sexually transmitted diseases claim increasing numbers of victims, and where women may be deterred from the effective use of contraception by other reproductive health problems, we must seek to design programs that take those realities into account and address them.

We must also reexamine how we address the needs of women at risk of unsafe abortion, and, even worse, women trapped in cycle of repeat abortions—and all that implies in suffering for them, and for their children and other members of their families.

Let me emphasize that increasing access to contraceptive information and service is our first line of approach to addressing the tragedy of unsafe abortion. We must improve the quality of care and increase the use of safe and effective methods. We must improve counseling and help women and their partners better understand reproductive health and reproductive choice. Equally important, we must work for compassionate treatment of all women who are in such desperate circumstances that they are driven to seek an unsafe abortion.

This issue, which has been at the forefront of public policy debate in this country, takes on an added urgency for many women in developing countries. They have far fewer choices than women here about where to turn for help. This administration will continue to stand for the principle of reproductive choice. We stand for the principle that all women should have access to a full range of reproductive health services.

Finally, I want to address the opportunities I see for USAID to strengthen our partnerships with others. Through diverse partnerships, we can multiply our influence, our resources, and our impact.

Within the government, the State Department is a key partner for USAID in policy dialogue, leadership, and coordination. We have worked closely together in recent months, developing the principles to guide the international population policy and programs of this administration. Counselor, soon to be Under Secretary, Timothy Wirth has communicated this policy widely. His initiatives with Japan have provided the impetus for enhanced USAID cooperation with the Japanese and a dramatic increase in both bilateral and multilateral assistance from Japan for international population and AIDS programs. The Cairo Conference will provide a tremendous boost to all our efforts, and I know Tim Wirth will be discussing this with you further.

I would like to acknowledge the role played by those of you from advocacy groups, as well as from the academic and research communities. My colleagues and I have had an opportunity to meet a number of you during our first months in office. By helping to communicate what we do to a broader public, by exposing us to new ideas, and, sometimes, by assuming the role of sharp and knowledgeable critics, your involvement makes possible the kinds of changes I have discussed today. Your efforts and your ties to counterparts in other countries enable us to extend our influence far beyond our dollar investment.

For those of you who are associated with the Cooperating Agencies, I would like you to know we consider you to be members of our extended family. Although your missions and ties to USAID vary enormously, you are the heart and soul of our programs. As we have pursued reform of the Agency, we have endeavored to strengthen our management by creating personnel, budgeting, and procurement systems that are better adapted to current needs. As the meeting proceeds, there will be more discussion of these changes. They are designed to strengthen our partnerships and to help you work more efficiently and effectively. So many of our friends in the Cooperating

Agencies express nothing but frustration in dealing with USAID. I want you to know that we are very aware of your concerns.

Our primary partners, of course, will always be the people of the developing countries, now joined increasingly by the people in Eastern Europe and the New Independent States of the former Soviet Union. We will dedicate ourselves to building a stronger sense of trust, reciprocity, and mutual accountability with those with whom we collaborate in the developing world.

We welcome all of you to join us as partners in translating our strategy into stronger programs in the field and measurable changes in the real world. I am grateful for your efforts. I look forward to your questions this morning and to your continued partnership into the future.

THE ROAD TO CAIRO AND BEYOND: TAKING LEADERSHIP ON GLOBAL ISSUES

TIMOTHY WIRTH

Thank you all for coming. It is a pleasure to be with you today in our continuing effort to forge a strong partnership between the State Department and USAID. This collaboration is reflected in the work being done by Liz Maguire, Duff Gillespie, and Faith Mitchell, our Senior Coordinator for Population. It is also reflected in the wonderful experience I have had working with Brian Atwood, whose creativity and commitment is propelling not just the issues of population but the Agency as a whole to the forefront of our foreign policy efforts. Brian Atwood is our number one ally, and we are grateful for his superb leadership.

I am delighted to join you today to discuss the changing nature of national security around the globe, in particular the emerging recognition that your work is central to the world's sustainable development agenda. These are top priorities for the Clinton administration, and I am looking forward to sharing some thoughts with you and hearing reactions and questions.

The changing nature of national security is reflected in this time of enormous transition for our country and the world. Together, we face a range of unfamiliar challenges in a world itself so unfamiliar as to be nearly unrecognizable. We are grappling today with a set of novel concerns in the uncertain setting of inescapable, disorienting, fast-forward global change.

I have personal understanding of some of that change.

In August of 1961, as the Berlin Wall rose, I was an Army private, the Cold War was an all-consuming reality, and we thought we were about to be shipped off to war in Europe.

Thirty years later my children and some 750,000 other young people from all over Europe sat on the remnants of that same Wall to hear a Pink Floyd concert. The Cold War, in the vernacular of their generation, was "toast."

During the forty-odd years of the Cold War that preceded these breakthroughs, security was defined in terms of the West's capabilities to withstand the military and political dimensions of totalitarianism. This was no simple matter. It consumed the collective mind—and the national treasuries—of the free world. It defined our goals and ourselves, our national priorities, and our personal lives.

But in the wake of that victory, there has been little of the calm after the storm.

The changes and the choices that the United States and the world community now confront are every bit as demanding as those we have known since 1945. The nature, diversity, and speed with which the new challenges proliferate dictate a new understanding of the meaning and nature of national security and the role of individuals and nation-states in meeting new tests and forging a better world.

Last fall, President Clinton delivered a far-reaching foreign policy address to the United Nations General Assembly in which he described how the United States is working to deal effectively with some of the new realities in the post-Cold War world. The President outlined three central themes: peacekeeping, nuclear non-proliferation, and sustainable development.

The first two, peacekeeping and nuclear non-proliferation, have received the most attention in the media and most closely resemble the more traditional diplomatic and military definitions of national security. Less familiar is the very high priority that the administration gives to the various elements of sustainable development, and it is to these that I would like to turn my attention this afternoon.

Like the United States, nations and institutions of the world are trying to make the crucial transition into a new ordering of priorities. Already, opportunities have been seized for fuller forms of international political cooperation than would have seemed imaginable only a few years ago, such as major multilateral peacekeeping efforts and cooperative efforts to root democracy and rebuild economies in Eastern Europe.

But these are not the only—or even the most elusive—challenges for the globe or the individual and collective well-being of nations. A set of novel, complex, and cross-cutting trends are replacing East-West military confrontation as new determinants of global security.

Perhaps most widely discussed is the emerging crisis of global environmental decline. The multifaceted assault on the global commons is surely compromising global security by slowly degrading our planet's life support systems.

The loss of land and soils stretches our ability to provide food in support of even today's population. Human activity has destroyed 10 percent of the globe's arable land, and the destruction continues at an alarming rate. The decimation of forests and species around the world is not only a loss of our inherited genetic promise but also a dereliction of our duty as stewards. And perhaps most telling of all, the increased carbon content of the atmosphere is a barometer of how we are altering our environment and our world.

Like environmental pollution, transitional health concerns respect no border. Inadequate access to maternal health care, contraception, and unsafe abortion leaves more than 500,000 women dead each year from preventable, pregnancy-related causes. A host of easily preventable diseases—from polio to vitamin deficiencies—also spread suffering around the globe. And AIDS, almost unknown a decade ago, holds the seeds of a public health disaster as devastating as the plagues of the Middle Ages.

Third, as reported in the State Department's Human Rights Report, the world is far short of the vision we hold for the freedom and dignity of individuals. The United Nations Charter affirms the "dignity and worth of the human person." In too many places, human dignity is assaulted, violence is perpetuated, discrimination prevails, and political repression is unchecked. This is not just a moral tragedy, but a barrier to the engagement of the most important resource we have for sustainable development—people. Most troubling is the denial of the political, economic, civil, and legal rights of women.

Central to all of these concerns, in my view, is the spiral of population growth. If, every 10 years, we go on adding a billion human beings to the planet, the human population will triple from today's 5.6 billion to almost 15 billion by the end of the next century. To stand by and let that happen would be to condemn not just nature but humanity as well. Continued rapid population growth will diminish

every hope of social, economic, and environmental progress in the developing world, and every humanitarian endeavor.

Rapid population growth is already a force contributing to violent disorder and mass dislocations in resource-poor societies. Some of these migrants are our near neighbors. Others—refugees-in-waiting—press hungrily against the fabric of social and political stability around the world.

Make no mistake—these trends are not solely concerns generated by events elsewhere on this globe: The appetite of the affluent for timber products is a menace to forests in Malaysia, Indonesia, Brazil, and the United States. The bulk of the underground water being drained away from our future flows into the shining cities of the "haves," not the parched lands of the "have-nots." Those same cities—and we who live in them and the way we live in them—are the furnaces of global warming.

These are frontier issues for us all—economically, politically, and spiritually. We are only beginning to recognize the extent to which human rights, health, environmental protection, the North-South partnership, and economic and social progress are all interrelated determinants of and prerequisites for sustainable development.

The interconnectedness of these issues to our population agenda is reflected in several broad themes that are emerging in international dialogue—all pointing the way toward sustainable development and a better life for all:

- There is broad agreement that population growth and consumption patterns play major roles in the constellation of factors which cause environmental degradation.
- There is increasing recognition that development and family planning can work independently to slow population growth, but that they work best when pursued together.
- It is widely agreed—and echoed in the World Bank's 1993 Human Development Report—that family planning programs should be a core element of global efforts to provide comprehensive reproductive health and primary health initiatives.
- It is well understood that a successful population strategy must be integrated with initiatives for education, especially for girls, increased economic opportunity for women, and the elimination of legal and social barriers to gender equality.
- Finally, there is recognition that efforts to slow population growth abroad must be matched by determined, good faith initiatives to reduce resource consumption at home.

It is these broad themes that underlie the Clinton administration's efforts to mobilize the world and translate this policy on a grand scale.

While the challenges are daunting, the transformations of the past few years impel us to reconsider the dimensions of what is possible. If Gorbachev and Yeltsin can discard communism and end the Cold War, if de Klerk and Mandela can work together to end apartheid in South Africa, if Israel and the PLO can break a fifty-year stalemate, should we merely peg our aspirations to what seems possible today?

There are plenty of sound reasons for hope. For all the suffering still in the world, we can say that in the last 50 years we have made more progress in alleviating human misery than in the previous two millennia. Life expectancy in the developing countries grew by one-third, death rates for infants and children were cut by half, and real incomes more than doubled. If we could do all that while

burdened with the political and economic costs of the Cold War, how much greater should be the goals we set for ourselves in 1994?

That is why now, almost halfway through the last decade of the 20th century, we have an unmatched opportunity not only to develop a plan of action for family planning and population stabilization but also to launch a comprehensive effort to create sustainable development for the benefit of current and future generations.

Specifically, what might we realistically define as a central agenda for the Cairo Conference and sustained, priority action in the remainder of this century and on into the 21st? Let me offer a few suggestions. These priorities do not fully define our agenda, but if Cairo could launch action on these challenges, we can make significant progress toward stabilizing the world's population, improving the quality of life for millions of individuals, and realizing the promise of sustainable development.

First, meeting the unmet demand and need for and expanding the range of reproductive health services must be a top priority. As many as 300 million couples around the globe do not have access to quality information and services. To bridge this gap, a determined cooperative effort must be launched to make quality, voluntary family planning and reproductive health services universally available early in the next century. This is one of the most important steps we can take to enable women—and men—to make choices about their lives and would be one of the wisest investments we could make for the 21st century.

Second, beyond quantity, improving the **quality** of services available around the world must be high on our agenda. Expanding the methods individuals are able to choose from, improving their distribution, and ensuring that providers have the technical background to competently deliver these services will greatly enhance not only people's lives but also our chances of realizing voluntary family planning goals—so, too, would better continuity in care and consistent, thorough follow-up. These are characteristics of the capable, quality services we have a responsibility to provide—and characteristics of programs that recipients want to use.

Investing in the wisdom of women is a third priority. The failure to educate females is tragic not just for human intellectual development but also because it contributes to the low status of women, infant and maternal mortality, and poverty. It is imperative that we close the enormous gap in educational opportunity that exists for gender reasons alone so that girls are able to fully realize their intellectual, economic, and political potential. As Population Action International has highlighted in a recent report, gender equity in education promises to yield enormous dividends for both our population and development objectives.

Fourth, we need to adapt the world's population and development programs to address the unique problems faced by adolescents. One of the most effective ways we can reinforce health, educational, and economic objectives is through special attention to the needs of young women. In addition to providing adolescents with all-important information and opportunity, we need to ensure that young girls are recognized for their full economic and social potential. We know that this strategy will help delay pregnancy and slow population momentum, but we can only begin to appreciate the genius that would be unleashed if young women are vested with societal expectations beyond marriage and childbearing.

Fifth, as women are empowered, so must we empower—some would say enlighten—men to accept their responsibilities related to fertility. As ever, men exercise more than their fair share of power in decision making related to family planning and reproductive choice. Men the world over need to accept and fulfill their responsibilities for promoting the rights of women, for pre- and post-natal care, for child rearing, and for preventing the spread of sexually transmitted diseases. A similar responsibility exists in the foreign policy establishment. Population and health are everyone's urgent business and deserve serious attention and personal engagement. Real men can work on population policy.

Finally, and perhaps most importantly, we need to establish a North-South partnership recognizing the mutually reinforcing roles and responsibilities of developed and developing nations. From the South, this will require a commitment to make family planning, health care, and women's empowerment among the highest national priorities. From the North, a corresponding commitment is necessary—in our willingness to help provide the financial wherewithal to realize an integrated global population strategy and in our readiness to take on the difficult issue of resource consumption and the disproportionate impact we have on the Earth's environment. And from both sides, we must have and we must generate the political will at the highest levels of government to live up to these responsibilities.

This agenda is not costless and certainly not barrier-free. The past, as Robert Kennedy used to say, yields most painfully to the future. The question is no longer what to do; the question is why do we not do what so clearly needs to be done, and how do we catalyze the political will necessary to do the job.

Successfully defined, the agenda outlined at Cairo will not only help us voluntarily reduce rapid population growth but also send benefits rippling across nations, economies, and, most importantly, the lives of present and future generations.

In the past year, President Clinton and Vice President Gore have guided the United States toward international leadership in promoting sustainable development. Nowhere has their commitment been more profound than with respect to population.

Beyond refunding the United Nations Population Fund and reversing the Mexico City Policy, the gag rule, and the research ban on RU-486, the President has encouraged us to develop a comprehensive and far-reaching new approach to international population policy. The President's commitment was reflected in the successful call for an additional \$100 million for population programs in his first budget and his recent request for almost \$600 million for core population activities in 1995.

Our policy is also reflected in Brian Atwood's outstanding work to infuse USAID's development efforts with the broadest possible gender-related approaches in credit for women-owned and -led agricultural and business enterprises, in democracy and human rights, in education, in the environment, in improved reproductive health care, and in major health crises such as HIV/AIDS.

We are exerting similar leadership efforts with our international partners. Recently, President Clinton announced successful efforts by the United States to encourage the Japanese to take on the population issue more aggressively. This initiative will infuse more than \$3 billion over the next seven years for comprehensive programs to reduce population growth and stem the spread of AIDS. Japan has begun to move, and we will now turn our sights to other donors in a determined

effort to ensure that the global resource base will reflect the priority this administration and the world are giving the population challenge in 1994.

Through these efforts, we are committed to promoting international consensus around the goal of stabilizing world population growth through a comprehensive approach to health care, the rights and needs of women, the environment, and development. These are the underpinnings of a new partnership among nations on behalf of enhanced quality of life for individuals, as well as the future habitability and stability of the world.

In 1948, when the notion of space exploration was still science fiction, the astronomer Fred Hoyle said, "Once a photograph of the Earth, taken from the outside, is available,...a new idea as powerful as any in history will be let loose."

Twenty years later, when space travel became a reality, the travelers themselves provided powerful testimony to Hoyle's sense of the unity of the world. Let me read to you from our own astronaut, James Irwin: "That beautiful, warm, living object looked so fragile, so delicate, that if you touched it with a finger it would crumble and fall apart."

And now from a Russian cosmonaut: "After an orange cloud—formed as a result of a dust storm over the Sahara—reached the Philippines and settled there with rain, I understood that we are all sailing in the same boat."

In this last decade of the millennium, we have the power and enormous responsibility to captain that boat carefully. We have the ability to harness these understandings and shape change for the benefit of the United States and the entire world. The interests and intellectual capacity reflected in this room today bear a special burden in this regard. For 12 years, in the face of significant obstacles, you have maintained the quality and creativity of U.S. population programs—and they remain the best in the world. Today, with an administration anxious to forge common cause, your talents, your energy, and your power is more than the match for the challenges we face. I hope that each of you will engage in this effort and that we can harness that energy and wisdom in service of these objectives. Our future certainly depends on it.

USAID'S OFFICE OF POPULATION: PROGRAM PRIORITIES AND CHALLENGES

ELIZABETH S. MAGUIRE

The past year has been an exciting and eventful one for all of us in the Office of Population and in the population community at large. We have much to celebrate with a new committed leadership at USAID and State, new policy and program directions, and increased resources. During this transition period, we have reached out to colleagues within and outside USAID to begin a new dialogue and to examine new program approaches and opportunities.

1994 promises to be an equally exciting and challenging year. Although we are still operating with some organizational and administrative uncertainties, we, in partnership with our Cooperating Agencies, must now begin to translate the new commitment to population and reproductive health into effective programmatic action. This action must lead to real improvements in reproductive rights and choice, in the quality and use of services, and in the well-being of the women, children, and men in the developing countries we serve.

Let me turn now to some of the program priorities and challenges ahead for the Office of Population.

Program Priorities and Opportunities

During the past year there has been open discussion and debate with old and new colleagues about key policy and program issues and priorities in family planning and reproductive health. Over the coming months, we will be undertaking an in-depth review of our portfolio in order to identify how best to pursue new opportunities. We will also be reviewing our current structure to determine the most effective configuration in the future to undertake new initiatives. We will be working closely with our partner Offices in the Center and developing joint responses to issues that cut across the population, health, and nutrition sector.

Family planning will remain the centerpiece and predominant component of the Office of Population's program. As Brian Atwood noted earlier, family planning has immediate benefits for the health and well-being of women and children and is the most cost-effective intervention for lowering fertility. Because of USAID's 28-year history in this area, its extensive network of specialized CAs, and its technical expertise and broad field presence, we have a unique role to play and a strong comparative advantage in family planning. Family planning is the foundation that must be further strengthened and upon which we can build new activities. In many settings, family planning programs can be broadened to include selected reproductive health interventions that will not diminish the family planning effort but will improve program impact and address important women's health needs.

There are five programmatic priorities for the Office of Population: Maximizing Access and Quality of Care; Addressing the Needs of Adolescents; Reducing the Tragedy of Unsafe Abortion; Adding Selected Reproductive Health Interventions; and Examining and Strengthening Linkages with Related Areas.

First, **Maximizing Access and Quality of Care** is fundamental to achieving our objectives. The Office of Population has supported a wide variety of efforts through our network of Cooperating Agencies to improve access and quality of care. Over the past several years, these efforts have taken various forms, such as the Informed Choice Task Force, the NORPLANT® Task Force, the Working Group on Quality Indicators in Family Planning, and a working group on medical policies and practices. A number of tools and methodologies to assess and improve quality of care have emerged, such as Situation Analysis developed by The Population Council, the COPE methodology developed by AVSC, Clinic Management Systems developed by IPPF/WHO, client satisfaction studies, and others.

We have held several meetings in the past few months on Quality of Care and Medical Barriers to review our collective experience and to begin to build an even broader effort. We have benefited from the frank exchange of ideas, and this participatory process has stimulated our efforts to strengthen and improve our program. We see the new title "Maximizing Access and Quality of Care" (MAQ) as encompassing not only the concepts of removing a variety of barriers but also other important activities focused on improving access to and quality of services.

The seeds of our collective efforts are now bearing fruit, but much remains to be done. As we work to provide the broadest possible range of fertility regulation options and offer selected reproductive health services to clients, we must do more to ensure that providers are technically competent and that appropriate medical guidelines and service practices are used. We must discover ways to improve the information flow between clients and providers. We must provide client-oriented services and increasingly women-managed and women-centered programs. We must design our programs with sensitivity to gender relationships that affect both women's access to and use of contraception. We must continue to develop qualitative as well as quantitative methodologies to understand the client perspective and to continually improve program performance. During the course of this week, you will help us further define how we can best work to maximize access and quality of care.

A second priority is **addressing the needs of adolescents**. By the year 2000, more than half of the developing world's population will be under the age of 25. Between 20 percent and 66 percent of girls 15 to 19 years old in developing countries have an unmet need for family planning services. In many countries, this need extends to even younger girls. Yet, family planning and other health programs frequently deny adolescents access to services. As a result, adolescents face high rates of HIV/STD infection, induced abortion, and high-risk pregnancy.

By working with the very young, we can help influence lifetime reproductive behaviors and decisions. Many of you already have innovative projects that address the special needs of adolescents. We want to learn from your experience and begin to build more adolescent-specific activities into our portfolio. We will be increasing the level of program resources devoted to adolescents. This year we will focus on interventions that can be introduced within existing projects, particularly in the areas of policy, IEC, training, operations research, and service delivery. Next year, we plan to develop a joint adolescent reproductive health project with the Office of Health and Nutrition.

A third priority is **reducing the tragedy of unsafe abortion**. It is estimated that over 25 million abortions are performed annually in developing countries and that up to 40 percent of maternal deaths are due to abortion and abortion complications. Under the Helms Amendment, USAID is prohibited from paying for abortion as a method of family planning. However, there is a great deal we can do—and will do—to deal with this issue more openly and humanely. We will focus increased attention on studying abortion, its complications, and its consequences and on supporting training in post-abortion care and post-abortion contraception. The provision of post-abortion family planning has a key role to play in preventing both subsequent abortion and the tragic consequences of abortion for women's health. In order to examine the technical and programmatic issues, we will be convening a joint working group of the Offices of Population and Health on the prevention of unsafe abortion and its sequelae. In addressing this priority issue, we will seek the input and expertise of our Cooperating Agencies and other partners.

A fourth priority is **adding selected reproductive health interventions**. The Office of Population has initiated an in-depth examination of key reproductive health interventions through a series of working groups, meetings, and technical reviews to identify major program issues and options. This effort has benefited greatly from the inputs of the Joint Reproductive Health Task Force, whose members include staff of the Offices of Population, Health, and Nutrition and Women in Development.

In collaboration with our PHN Center partners, we recently launched a survey of reproductive health activities supported by USAID Missions and CAs to serve as a baseline for future assistance. Preliminary findings indicate that there are already a wide variety of innovative reproductive health activities under way in the field. These findings will be presented later in the meeting. Another initiative is being launched by the National Academy of Sciences with funding from USAID and various foundations. A panel of experts will be formed to examine reproductive health needs in developing countries and the cost-effectiveness of interventions.

The strategy of the Office of Population when moving into new territory has always been to take a phased approach—to test and examine new ways of expanding contraceptive choice and improving service delivery on a small scale, introduce modifications as needed, and then replicate pilot efforts on a larger scale. We will follow this successful approach, used in introducing community-based distribution and contraceptive social marketing, to support key reproductive health interventions in family planning programs. Obviously, what we do and how we do it will vary according to each country's particular needs and setting.

Our guiding principle will be to focus on reproductive health interventions that will benefit the most women at an affordable cost and have the highest public health impact. The areas of family planning, breastfeeding, post-abortion contraception, safe motherhood, and HIV/STD prevention will receive special attention.

Through operations research, pilot and case studies, and survey efforts, we will examine empirically how key reproductive health interventions can complement and reinforce family planning. The new family planning research field station in Ghana will be an excellent vehicle for testing and evaluating reproductive health service delivery strategies. Finally, we will monitor, document, and evaluate the cost-effectiveness of integrated programs and ensure that family planning and other key interventions are not compromised.

We certainly do not have all the answers now. We will be able to incorporate selected reproductive health interventions more quickly into some areas of the Office's ongoing program than others. For example, it will be relatively easy and inexpensive to include reproductive health messages into family planning IEC campaigns, raise reproductive health issues in the course of policy dialogue with host-country leaders, and address reproductive health questions in ongoing research. Many of our training programs already include selected reproductive health interventions in addition to family planning.

A high priority this year will be to begin to launch operations research activities and case studies of integrated family planning/reproductive health services. With time and adequate resources, the Office's entire portfolio will increasingly reflect a definition of population that includes both family planning and selected reproductive health interventions.

A fifth priority is **examining and strengthening linkages with related areas and programmatic synergies**. Family planning and reproductive health decisions are not made in a vacuum, and it is important that we improve our understanding of the less proximate determinants of behavior and address them as appropriate. At the policy level, for example, there is much more that can be done to promote girls' education and improve the status of women that will have positive consequences for contraceptive use, child spacing, and maternal mortality. We must encourage the development of population policies and policies in other areas that are consistent and complementary. Stronger cross-sectoral linkages may also be beneficial at the service delivery level. For example, CARE is experimenting with complementary family planning/natural resource programs—co-locating these programs and training staff in each to provide referrals to the other. There are also opportunities to incorporate family planning concepts into child survival and maternal health programs. We will be discussing some of these programmatic linkages in separate break out sessions on female literacy and education, gender, child survival, and the environment.

Challenges Ahead

The 1990s have been labeled "The Critical Decade" for population programs. The need for family planning and reproductive health services is enormous and growing. Resources, however, are not growing as fast. In order to meet the needs, we must

- **Maintain a focused and balanced program**, while improving quality, coverage, and impact. The Agency's new population and health strategy describes global goals for the development community—stabilizing population growth, improving maternal and child health, and slowing the spread of HIV/AIDS—to which USAID's program will contribute. Our population efforts must have an impact at the individual, country, and global levels. We must reach as many people as possible without compromising quality and individual choice. Operating within resource constraints, we must find the right balance between increasing our attention to reproductive health, without diminishing the family planning effort, and maintaining our ability to have a measurable impact. This CAs' Meeting is an important opportunity to examine policy and program issues in the family planning and reproductive health arena that are critical to meeting these goals.

- **Build new partnerships within and outside USAID.** Reaching the goals I mentioned requires combined and coordinated efforts; we cannot do it alone. We need to expand and strengthen the constituency for family planning and reproductive health both here and abroad. Building on common ground, we must work more closely with women's health advocates, environment groups, other community organizations, and minority-serving institutions. We have much to learn from each other's experiences and perspectives that will strengthen family planning and reproductive health programs worldwide.

We must build stronger partnerships with host-country public and private sector institutions at all levels. Programs will reach their full potential and be sustainable over the long term only if local institutions, local communities, and particularly local women, are full partners in program design, implementation, and evaluation.

- **Strengthen donor coordination.** In recent years, there have been notable improvements in donor coordination at all levels. But we must do more. Key areas for more coordinated effort include the provision of contraceptive commodities and condoms for HIV/AIDS prevention, reproductive health services, policy dialogue, program evaluation, and resource mobilization. To meet the escalating needs, donor and host-country resources allocated to family planning and reproductive health must increase substantially. However, even at current resource levels, our reach can be expanded and our impact increased by building more systematically on the comparative strengths of each donor and the complementarities that exist among programs.

We need your help to improve family planning and reproductive health programs. This CAs' Meeting is an opportunity to build a new vision of what USAID's population program should and can do and begin to move from dialogue to action. We are excited about the opportunities to work more closely with our colleagues in the Health and Nutrition Office; to strengthen collaboration with the Women in Development Office and other Centers in the Global Bureau; to expand in new directions with old partners; and, finally, to welcome new partners and build new coalitions.

POPULATION: PROGRESS AND CHALLENGES

STEVEN SINDING

I am very pleased to be here. It is always a special pleasure to come back to USAID. In 22 years with the Agency, I developed both great admiration for your work in the population field and great affection for many of you who are gathered here today.

My assigned task is to provide a demographic overview and a framework for the many specific discussions that will follow over the next two days. I will do that, but I want to do so in a way that relates the demographic situation to some of the more interesting and perhaps contentious discussions that are going on today about the relationship between population and development, the reproductive health perspective, and alternative approaches to intersectoral collaboration and funding.

As an audience of professional population people, you are all aware of both the bad news and the good news on the global demographic front. The bad news is that an unprecedented number of young people are entering the reproductive age group so that, even if average fertility declines over the next couple of decades, the total number of births will increase quite substantially as we pay the price for high fertility in the recent past.

Figure 1 demonstrates this phenomenon quite clearly. The number of women of reproductive age will increase very substantially, from around 600 million in 1980, to over a billion in 1990, to close to 1.5 billion by the year 2010, and so on. Thus, even if we should reach replacement level fertility of 2.1 children in the very near term, the absolute number of births will increase at least through the first two decades of the next century.

That's the bad news. The good news, of course, is that access to reproductive health and family planning services has increased substantially and average family size has declined precipitously since it peaked in the mid- to late-1960s, declining from a total fertility rate of over six in the developing countries to today's level of somewhere between 3.6 and 3.9. This decline in fertility, of course, has been accompanied by improvements in maternal and child health and survival rates. Figure 2 shows average family size declining by over two children between 1965-70 and 1990, while desired family size has declined from around four children to slightly under three children over the same period of time. The reduction in actual fertility is, of course, powerfully influenced by China's extraordinary—in every sense of the word—demographic performance. Even so, the narrowed gap between desired and actual fertility is also testimony to the tremendous impact of organized family planning programs—helping to reduce unwanted fertility by half over the last 25 years. In 1965, the average woman in the developing world had two more children than she wanted. By 1990 that number had been cut to one. Nonetheless, even at this level, there are well over a hundred million women today in the developing world who have an unmet need for contraception.

Figure 3 shows what the impact would be in the year 2100 if all unwanted pregnancies could be averted immediately. The result would be a developing world population which John Bongaarts estimates to be 2 billion less than the U.N. median projection of approximately 10 billion people by that year.

Let us review the geographic distribution of unmet need. We can see in Figure 4 that the total demand for contraception varies considerably among the three major regions of the world as does the extent to which that demand is satisfied. One can see from the graph that total demand is highest in Latin America followed closely by Asia/North Africa and that both regions have **relatively low levels** of unmet need. (I should note that even though **proportions** of unmet need are lower in Asia, the absolute number is still large, e.g., India has over 20 million women with unmet need.) In Africa, by contrast, while total demand is considerably lower than it is in the other two regions, the unmet need is nonetheless very large, suggesting that the demand for contraception is certainly strong enough to justify a significant investment in family planning programs and services.

Let me make a short digression on the definition of unmet need as measured by surveys such as DHS. Unmet need is usually defined as the percentage of fecund women not currently pregnant who say they want no more children or say they want to space their next birth by at least two years and are not presently using a method of contraception. The logic of the inconsistency between aspiration and behavior suggests that they have a need for contraception. Critics of this measure have said that need is inferred by the analyst rather than expressed by the women interviewed. It is, indeed, true that some of these women, when asked, say they have no intention of using contraception in the future. Do these women have an unmet need?

This brings us to the more complicated issue of reasons for non-use. I think of this in terms of a continuum, ranging at one extreme from non-use despite active demand due to actual lack of physical access to contraception, to the other extreme where strong social and cultural barriers make the use of contraception very unlikely even when it is available and even when a woman says she actually wishes to remain non-pregnant. At one end of the spectrum, non-use can be remedied by adjustments in program factors. Here, the quality of services is often crucial, and improvements in quality almost certainly will lead to significant increases in effective contraceptive use and the rate of continued use. At the other end, reasons are more deeply embedded in cultural and social factors and are probably beyond the reach of program activities, at least in the short term. In other words, unmet need, despite apparent precision, does not tell the whole story about demand for contraception.

Unmet need is also a moving target in the sense that as programs expand and improve, the demand for contraception usually expands rather quickly as well. We know this from the experience of many countries and from the fact that unmet need at one point in time is an excellent predictor of contraceptive use at a subsequent point in time. High-quality services more and more appear to generate their own demand.

Many people used to ask: How are we going to get developing country women to practice family planning? Many governments answered with demographic targets and family planning quotas. Today we know from 25 years of research that we were asking the wrong question. We should have been asking how we can help these individuals and couples to meet their own goals. Research shows that in most countries, responding to people's needs will result in

higher levels of contraceptive use than applying the top-down targets and quotas that many countries continue to set. This can be seen from Figure 5. In an analysis I did about a year ago, looking at levels of unmet need and comparing these with the targets and quotas various countries had set, I found that in 13 of 17 countries, responding to women's needs exceeds the targets. Helping couples do what they want works better than bureaucrats and planners setting goals based on an abstract notion of what the birthrate should be—often deduced from economic targets in development plans.

Twenty-five years ago we knew very little about the demand for contraception or family planning. Many pessimists in the academic community as well as among planning ministries and development agencies around the world felt that targets were needed to inspire actions that would result in contraceptive use among those who were not then motivated to use contraception. I have to confess that, for a time, I was among those pessimists. Today we have considerable evidence that the demand for contraception is much greater than many of the pessimists 25 years ago believed. We think that strategies aimed at satisfying demand are likely to be far more effective than strategies aimed at artificially inducing demand. In other words, in the great majority of countries, there appears to be no conflict between individual reproductive goals and the objective of reducing population growth.

Figure 5 shows three things for each country. The upper bar shows the government target in terms of prevalence of contraceptive use. The lower bar shows current contraceptive use and unmet need—together they equal total demand. As I said, in 13 of the 17 cases, the combination of current use and unmet demand exceeds the government targets. The exceptions can be explained either by extremely high levels of current contraceptive use along with the ambitious targets—the case of Thailand—where the difference between the target and total demand is practically insignificant, or by extremely low levels of contraceptive use in the face of ambitious targets, such as Haiti, Ghana, and Nigeria. In the other countries, including those in Africa, meeting unmet need is more than sufficient.

Let us turn to Figure 6 which shows the gap between desired fertility and actual fertility and ask, what explains the difference between current desired fertility and replacement level fertility? In other words, why do people continue to want more children than they need to replace themselves? We know, of course, that the answer to that question is related to a host of social and economic conditions that influence the way parents view children. There is much evidence to suggest that two of the most powerful determinants of desired family size are infant mortality experience and the role, status, and opportunities for women. Women's education appears to exert powerful influence on contraceptive use and fertility.

Clearly, replacement level fertility cannot be achieved by family planning alone or by meeting unmet need for contraception. Unless parallel progress is made in improving the conditions of women, the opportunities for women, and overall living standards, desired fertility will continue to be higher than replacement level.

I think of the investments in human capital that are required to achieve replacement level fertility and population stabilization like the three legs of a stool. Unless they are of equal length, the structure is unstable. In other words, each goal is dependent upon achieving the other two. Replacement level fertility will not happen unless substantial improvements in female education and child survival are achieved. Likewise, adequate progress on female education cannot be achieved in most countries at present fertility rates. High infant and young child mortality will not be reduced to desired levels as long as fertility is high and

universal primary education remains an elusive goal. The basic point is that these are not alternative strategies. They are synergistic components of a single strategy.

This brings me back to what I think is the heart of the matter for USAID. Figure 6 shows the resource requirements needed to meet the unmet demand for contraception at current levels of desired family size. It suggests that total global resources devoted to population and family planning need to increase from the present estimate of around \$5 billion to at least \$10 billion by the year 2020. Recent estimates from UNFPA are higher—around \$14 billion by 2015. In addition, much larger commitments are required to meet health and education goals. Most of these resources will have to come from the governments and people of the developing countries themselves, but obviously donor contributions must increase substantially, particularly over the next decade or two. Reaching the required levels implies almost a doubling in the contribution of the developing countries and an even larger proportional increase in the funding coming from other donor countries. The Amsterdam meeting of 1989 suggested that donors should increase their contributions from one percent to four percent of official development assistance (ODA). Norway is the only donor country which has reached this level. The United States has done relatively better than other industrialized countries, and the big increases projected for 1994 and 1995 by the Clinton administration are most encouraging in this respect.

USAID has long been the largest and, to my mind, the most effective donor in the population field. At the same time, the U.S. has been criticized for taking an overly narrow view in its approach to population, focusing on the supply side and not focusing sufficiently on the broader issues that affect desired family size. While these criticisms have been sometimes unfair, ignoring the fact that U.S. policy has always recognized the importance of a multi-sectoral approach in the population area, it is true that USAID historically has taken—and still takes—the view that the first order of business is to help individuals and couples realize their own reproductive goals. The evidence suggests, today more than ever, that this is an important, cost-effective part of population policy.

Let me be clear that I think USAID's **rhetoric** in years past was sometimes unfortunate, even counterproductive, particularly when the Agency sounded as if the supply side was the only side of the equation. As a result, USAID continues to have an image problem in some countries and with some key constituencies. I believe you can begin to remedy this image problem by broadening somewhat the Agency's definition of population programs and projects. Here's what I mean:

There is increasing evidence today that program-related reasons for unmet demand remain at least as powerful as the non-program related reasons and that the gap is more likely to be closed by focusing on improved quality of services and better quality information about services than by any other approach. To my mind, the critical need over the next several years is to improve the quality of services to the point that people who really want to avoid pregnancies will feel confident that they can do so safely, effectively, confidently, and with dignity. Embedding contraceptive services within a broader health framework makes a lot of sense to me. I urge USAID to accelerate your efforts to find cost-effective approaches to expanding health services as part of the drive to achieve high-quality care in the programs you support. By doing this, I think you can also go a long way toward overcoming some of the negative perceptions of USAID.

In a world of scarce and even declining resources for international development, cooperation, program complementarity, and coordination become more important than ever. Each agency should strive to focus on what it does best, giving the concept of comparative advantage true meaning in the development cooperation field. I firmly believe that USAID's comparative advantage is in field programs that deliver reproductive health and child survival services. USAID is the recognized world leader in expanding the availability of family planning services through both public and non-governmental channels. You should build on this strength to broaden your approach to reproductive health, especially quality of care, but should resist the temptation to **redirect** resources toward other important areas in which the Agency's programs are not as strong. More resources are needed for primary education in particular, and I subscribe to the UNDP and UNICEF formula that calls for 20 percent of all development resources to be devoted to the social sectors. I agree with the approach Nafis Sadik is taking for the Cairo conference: strongly supporting the need for increased resources for those human development programs that most strongly reinforce the goal of population stabilization and which are, in turn, so strongly dependent on reduced fertility. I believe the population community within USAID should do the same—argue for increased resources for child survival and female education programs. If significant resources could be found to increase the overall USAID budget, top priority should be given to female education and child survival programs. By the same token, the U.S. government should encourage other donors, most notably the World Bank, to undertake the essential investments, particularly in education, where the resource needs also vastly exceed bilateral resource availabilities.

Above all, I believe USAID will become more effective only to the extent that you say clearly and loudly that your objective is to help developing countries provide every support and opportunity that women and families need for a life of health, improved living standards, and individual dignity. If our objective is how can we stabilize the world's population, if meeting unmet demand is conceived only as an incremental step toward that goal, then we only have rephrased the question we asked 25 years ago—the question that turned out to be the wrong question: How can we get developing country women to practice family planning? The answer to that question is they will practice it when it is good enough in quality and makes sense in terms of all their needs and aspirations. Your objective, as the premier foreign assistance population program, should be to champion that dream and to always conceive of family planning as a resource for the needs and purposes of women, not the other way around. That is a powerful, human path to a world that will be better for all of us.

Your work over the past quarter century has truly made a difference and is part of one of the great development stories of our era. But much more remains to be done to assure every woman and every couple the means to achieve good reproductive health and full reproductive freedom. From what I have heard at this meeting—from Brian Atwood, Tim Wirth, and Elizabeth Maguire—you are already on the right track.

Thanks for giving me this opportunity to speak to you today.

FAMILY PLANNING AND REPRODUCTIVE HEALTH: OVERVIEW AND VISION

ALLAN ROSENFELD

I want to thank the organizers for the invitation to speak here today. After 12 years of administrations in Washington which were strongly opposed ideologically to the fields of population, family planning, and women's reproductive health, it is truly exciting to have an administration strongly supportive of programs in these fields. President Clinton demonstrated this dramatically within his first week in office by overturning the domestic gag rule and the international Mexico City gag rule. Since then, we have seen the administration take a strong stance in these areas, as expressed in the formal statements of Tim Wirth to the preparatory committee for the 1994 Cairo population meeting, on which he eloquently amplified in his luncheon address. This is certainly a dramatic and exciting change from the U.S. positions as expressed by Mr. Buckley at the Mexico City conference in 1984.

Yesterday Mr. Atwood presented a clear and very positive description of USAID's overall strategy in relation to population, the environment, and health. The strategy is broad based and well defined. We also heard a review of USAID's programs in the population/family planning field over the past two-and-a-half decades.

I would like to add my thoughts on USAID's record since the late 1960s. What has been accomplished during these years, in an area so filled with sensitive issues and controversy, has been truly remarkable. We have indeed seen an extraordinary reproductive revolution take place in much of Asia and Latin America, with dramatic changes beginning more recently in several countries in sub-Saharan Africa. USAID, despite the official administration stance between 1980 and 1992, has played a vitally important role in the changes that have taken place.

I was fortunate enough to see this change firsthand in one country, working in Thailand from 1967 to 1973 and following Thai development in this area ever since. It was an exciting time to be there, assisting the Thai government to establish what has since become one of the world's true success stories—what John Knodel and his Thai colleagues first coined as the Thai reproductive revolution. In 1967 the national contraceptive prevalence was estimated to be approximately three percent. None of us working there at that time would have dreamed that today the prevalence would be well over 65 percent.

I was asked to focus on a vision of the interface between family planning and women's reproductive health. We heard yesterday that helping to make contraceptive services as widely available and accessible as possible will continue to be a centerpiece of USAID's programming, as will a focus on the delivery of voluntary, high-quality services.

It is clear that the provision of family planning services helps to improve the health of women and children, helps to improve the status of women, helps women to achieve their stated goal of spacing or limiting the number of children, and helps to meet demographic goals of a decrease in the rate of population increase. Further, despite the fact that over 50 percent of

women or their partners in developing countries are currently using effective contraceptive methods, there remain millions of additional women who have stated that they do not wish additional children but are not currently using contraception, in most instances because of problems of access. In addition, millions of women will enter the reproductive age group each year.

However, there are other very important components of reproductive health that must be considered in the effort to meet the many needs of women. I would like to focus on five issues: gender, adolescent sexuality and pregnancy, STDs and HIV/AIDS, maternal mortality, and abortion. I will not discuss the issue of breastfeeding, except to say that it has great importance both as an effective method of contraception, particularly in the first months of postpartum, and as the best source of nutrition and passive antibody protection for the newborn infant.

Gender

Gender issues are coming increasingly to the forefront when one discusses women's reproductive health. These are issues that are of importance in all societies, but the inequities in some societies are extreme. There are many women who have great difficulty in making important decisions about their lives without their husband's permission. Some family planning programs assist women in making a confidential decision about contraception, in effect allowing them to use methods without the husband's permission or knowledge—a big step in some countries.

But many women fear harassment and even violence as a result of such decisions. It is imperative that gender be taken into consideration as expanded reproductive health programs are designed. This applies particularly to the sensitive topic of family planning programming. We must better understand the lives of women in different cultures and settings if we are to be able to most effectively serve their needs. The status of women is receiving much attention presently and will be a major topic of the 1995 U.N. Conference on Women. Clearly, high on the list will be the enhancement of women's status relative to the status of men and the way men and women interact. In developing broader reproductive health programs, attention needs to be given to an understanding of each cultural setting.

Adolescent Sexual Activity and Pregnancy

For the last 12 years, little attention has been given in USAID programs to the problem of adolescent pregnancy, despite the strong and urgent need. Ideological concerns of the previous administrations put a chill on USAID programming in this area. While there were insufficient data until recently, those involved in family planning and reproductive health programs have understood that unwed and unplanned teen pregnancy is a major problem in most developing countries, particularly in urban areas.

Thanks, in part, to recent analyses of DHS studies in Latin America, the Caribbean, and sub-Saharan Africa, we now have a great deal of information about adolescent sexual activity and pregnancy. In Latin America, the DHS data suggest increasing rates of pregnancy in recent years with resultant increases in births and almost certainly in the numbers of illegal abortions.

The data from Latin America suggest that approximately half of all female adolescents are likely to become pregnant and give birth at some time between the ages of 15 and 19 (with many having the first birth before the age of 15). Increasing numbers of unmarried teens are sexually active, and, depending on the country, between 22 percent and 63 percent of first births to married young women are conceived premaritally. In sub-Saharan Africa, between 20 percent and 50 percent (depending on the country) of adolescent women have a child, with anywhere from 20 percent to 50 percent of these women becoming pregnant outside of marriage. In Latin America, as in the U.S., significant numbers of young women, particularly those who are poor and live in urban areas, are sexually active at increasingly younger ages, with resultant risk of pregnancy, STDs, and HIV/AIDS.

I will not review the health and social consequences of teen pregnancy, as this audience is knowledgeable in this area. Instead, I will only stress that much time has been lost because of the attitudes of prior administrations toward this topic. But, with the new administration and the strategies expressed yesterday, the time has come for a concerted programming effort focused on teen pregnancy. Particular attention must be given to sexuality and family planning education in the home, in the schools, and through various public media channels and to the effective delivery of contraceptive services to those who are indeed already sexually active.

As in the U.S., creative, culturally responsive, adolescent-specific clinic programs have been developed, and there are already good examples in developing countries, such as CORA in Mexico City and the Population and Development Association in Bangkok. Much more is needed in countries throughout the developing world, and this should be a priority program area starting immediately. It is also important that personnel in existing programs be trained to be responsive to the needs of sexually active adolescents so that services can be delivered in a variety of settings.

Such efforts will need to be particularly sensitive to the cultural barriers that exist in this area. Throughout the developing world, early marriage and early childbearing is still common in more traditional, predominantly rural communities. As efforts to improve the status of women continue to be stressed, early marriage and childbearing is one of the targets for change. In poor urban settings, more and more sexual activity and pregnancy occurs outside of formal unions. Efforts are needed to discourage marriage of very young teens in rural societies, while also facing the issue of adolescent sexuality and pregnancy among young unmarried teens wherever they live.

STDs and HIV/AIDS

Judith Wasserheit, Chris Elias, and others have helped identify the seriousness of common STDs (often now referred to as reproductive tract infections or RTIs) among underserved populations. I include in this such diseases as gonorrhea, syphilis, chlamydia, herpes, as well as trichomoniasis and moniliasis. And, of course, we must add to this litany the tragedy of the HIV/AIDS epidemic. At a minimum, all population/family planning programming must include strong messages about the prevention of STDs and HIV/AIDS.

Those who have said, and still say today, that we must not mix family planning and STD services because it might somehow impact negatively on a family planning message or program are, in my opinion, simply wrong. One gets pregnant or is exposed to an STD

through the same activity, and separate programming as though this biologic fact does not exist does not make any sense. It is time to put an end to this debate.

The tragic AIDS epidemic has reinforced the importance of linking preventive messages, and there should be, at this point in time, general agreement about such linkages. Put simply, family planning programs must give attention to STD/HIV/AIDS prevention and STD/HIV programs must similarly give attention to family planning.

Further, the population and health offices of USAID need to make certain that the type of coordination that should take place in the field also takes place here in Washington. While it is my understanding that the Offices of Health and Population are now cooperating on the distribution of condoms, during the first years of AIDSCAP and its predecessor programs this did not occur. Since the Office of Population has such an effective logistics system built up over many years, it was inefficient—both from cost and program considerations—to have such little contact initially between the offices. Furthermore, significant additional funding is necessary for the needed numbers of condoms.

For the Office of Population, the question next arises as to its responsibility in relation to STD/HIV testing, counseling, and treatment. In principle, all three components should be available, but in practice the costs are great. This is a very difficult problem given estimates of the costs necessary to bring contraceptive services to the millions of women currently not using contraception despite not wanting more children or wishing to space pregnancy. The problem is exacerbated as the large and increasing numbers of preteens enter the reproductive age group each year. This is an extremely difficult dilemma, but at least one can agree to the importance of joint preventive programming in these three areas.

Maternal Mortality

One of the areas of incomprehensible neglect within health programming in the 20th century has been the tragedy of maternal mortality in developing countries. While maternal mortality ratios (the number of maternal deaths per 100,000 live births) fell dramatically in developed countries since the turn of the century, there has been little, if any, change in most developing countries. Ratios today in the poorer countries remain unacceptably high, and it is estimated by WHO that 500,000 or more women die each year of pregnancy-related causes, the vast majority preventable with existing technologies.

The major causes of mortality, in no particular order, are obstructed labor leading to rupture of the uterus, postpartum hemorrhage, toxemia of pregnancy leading to convulsions, postpartum infection, and complications of unsafe abortion (a topic to which I will return in a moment).

It is extraordinary that physicians, including obstetrician-gynecologists, public health professionals, public policy-makers, and the public in general have, in effect, ignored the tragedy of large numbers of women dying from pregnancy-related causes until very recently. The AIDS epidemic has appropriately received tremendous media attention and the allocation of very large (albeit still inadequate) sums of money, while the Safe Motherhood Initiative receives almost no international media attention and grossly inadequate funding support. Yet more women die each year of complications of pregnancy than the annual death toll from AIDS, at least at the present time.

Given this tragedy, what should be the agenda for USAID's new population and reproductive health strategy? At the outset, the single most effective intervention, at least in the short run, is making family planning services as widely available and accessible as possible. There are clear data linking maternal age (less than 17 and over 35) and parity (more than 4 or 5 children) to complications of pregnancy and pregnancy-related deaths.

Village-based programming, through such efforts as community-based and social marketing programs, together with the needed increased funding levels mentioned earlier, can help to bring family planning services to all those women who state they do not wish more children than they currently have. Estimates have been made that this step alone might decrease maternal mortality ratios by as much as 50 percent.

Certainly those who demonstrate their desperation not to be pregnant by undergoing unsafe abortion attempts will benefit by access to contraceptive services. It is necessary to state, however, that even with the use of contraception there will be many contraceptive failures in which abortion will still be sought, as evidenced by the fact that approximately half of the 1.6 million abortions annually in the U.S. are the result of contraceptive failures.

Beyond family planning programs, what is needed to reduce maternal mortality is the effective linkage of prenatal care with access to first referral centers that can provide emergency obstetrical care, namely, the capability to carry out a cesarean section, transfuse, provide intravenous antibiotics, and complete an incomplete abortion. First referral centers need not be tertiary medical centers but rather small rural hospitals that are properly equipped with trained personnel to meet the need for emergency obstetrical care.

With existing funding resources, the USAID population program is not well positioned to fund the training and equipping of new first referral facilities. But it **is** appropriate to begin the upgrading of facilities and personnel which currently provide surgical contraceptive services, particularly sterilization procedures. Personnel trained to carry out a sterilization procedure (either by laparoscopy or mini-lap) can also be trained to provide emergency obstetrical services.

It is not necessary to restrict such activities only to physicians. There are experiences in Zaire and elsewhere in which nurses and/or midwives have been trained to carry out surgical procedures safely. Although most medical societies oppose such activities by personnel other than physicians, the fact is that, with proper training and supervision, such personnel can be most effective.

In an effort to make a meaningful impact on this tragic problem, however, a truly effective collaboration between USAID, WHO, UNFPA, UNICEF, and the World Bank could lead to programming that would finally give meaning to the seven-year-old Safe Motherhood Initiative.

Abortion

I have left to the end the single most controversial issue in society today, namely, the right of a woman to terminate a pregnancy versus the rights of the fetus. No issue generates more heat than this, and none is less likely to be resolved in the foreseeable future. For those who believe that life begins at the time of fertilization or implantation, there is no middle ground;

abortion for them equates with murder of the unborn child. Similarly for those who believe in the woman's absolute right to control her own body, there also is no middle ground or compromise. However, whatever the legal status, women in all societies undergo unsafe abortion attempts with very high abortion-related mortality. WHO estimates that as many as 20 percent to 25 percent of maternal deaths each year are due to abortion complications.

Thus, in the year since the dramatic overturn of the Mexico City policy by the Clinton administration, 100,000 or more women worldwide died from complications of unsafe abortion. This, despite the fact that induced abortion—when performed by trained, skilled practitioners in hygienic settings, as in the U.S. since the early 1970s—is among the safest of surgical procedures. In much of the developing world, however, where abortion is illegal, women in desperation turn to untrained illegal providers who work in unsanitary conditions and carry out a variety of unsafe procedures. In some cultures, women may attempt to self-abort, using various unsafe approaches. The issue really should not be legal versus illegal procedures, but rather simply safe versus unsafe procedures, because, in just about every society and culture, there will be women who will take whatever step is necessary to terminate an unwanted pregnancy.

In addition to deaths, unsafe abortion is also responsible for the long-term injury of hundreds of thousands of women. Moreover, the economic burden on health systems due to the treatment of abortion-related complications is severe; in many urban hospitals, abortion complications account for a sizable percentage of emergency admissions to the gynecological service. In Latin America, for example, abortions are estimated to be the number one cause of maternal mortality and emergency admissions. The tragedy is exacerbated by the fact that such mortality and morbidity—and the associated costs to health systems—is largely preventable.

Now, a year into the Clinton administration, it is time to revisit the steps taken toward the implementation of the administration's "people first" approach as it relates to the morbidity and mortality women face from unsafe abortions. In his speech to the recent preparatory meeting for the Cairo conference, Tim Wirth stated that "the abortion issue should be addressed directly with tolerance and compassion rather than officially ignored while women, especially poor women, and their families suffer.... Our position is to support reproductive choice, including access to safe abortion."

The Office of Population already has made excellent progress by reformulating its programs to include an emphasis on improved reproductive health and choice for women. The provision of contraceptive counseling and services in the post-abortion period is considered a high priority within this new framework. However, much more should be done to meet the tragic consequences of unsafe abortion. USAID could have an immediate positive impact on women's health by supporting, at a minimum, programs for the emergency management of the complications of a botched abortion. It is time, for example, to fund the International Pregnancy Advisory Service (IPAS).

Currently, concerns about the type of abortion-related activities in which USAID can engage, given the Helms amendment, have limited programming in this area. To date, the Agency has not funded any programs or projects which provide services to treat incomplete abortions. One would hope that not even Jesse Helms would object to making services available to save the life of a woman suffering the complications of a poorly performed, unsafe abortion procedure. After carefully reviewing the Helms amendment, there appears to be nothing in the

amendment which would prohibit the treatment of an abortion that is incomplete, no matter whether it is spontaneous or the result of an unsafe attempt to abort. There is concern on the part of some that the equipment to treat abortion complications should not be distributed because the same equipment can be used to carry out an abortion. However, to **not** supply equipment to save lives for this reason is immoral and essentially medical malpractice. This equipment is needed and should be made available and accessible as soon as possible.

If USAID avoids this issue and is unwilling to provide leadership in this important area, then the administration's many achievements in the field of reproductive health and family planning are much diminished if hundreds of thousands of women continue to die or be permanently disabled as the result of desperate attempts to terminate unwanted pregnancies.

Now is the time for the administration to take the further courageous step of endorsing the funding of abortion-related activities to the fullest extent possible under the law, particularly authorizing USAID-funded programs supporting clinical family planning services to develop programs to treat the complications arising from unsafe abortion. Linking with the programs of such organizations as IPAS and the International Women's Health Coalition (IWHC), USAID Cooperating Agencies such as AVSC, JHPIEGO, Pathfinder, IPPF, and others can make the treatment of incomplete abortions a regular part of their programming, when so requested by governments or private agencies. Through such an initiative, many lives can be saved. This would be a highly appropriate USAID response to the rallying cry expressed by Mr. Wirth.

In addition, funding should be made available to study the impact of illegal abortions and to support policy discussions of the findings. Debates about safe abortion should be supported, when so requested by local authorities and groups, including discussion about the legalization of abortion when so requested.

Conclusion

This is an exciting time for those concerned about issues of family planning, women's reproductive health and rights, and population growth. After 12 years of administration policies that were opposed to programming in these areas, it is an exceptional opportunity to make major advances during the coming years. As stated earlier, it is remarkable how much has been accomplished in the field of family planning by USAID and other agencies, both foreign and domestic, during the past two decades despite the many obstacles that were placed in their way.

Much less was done in the area of women's reproductive health during this period of time, and it is imperative that we move forward in this area. There is much interest in the development of comprehensive programs, and the challenge is to set priorities within existing funding limitations in order to have the greatest public health impact.

First, there is an ever increasing demand to meet the unmet need for family planning services. The projected costs for this initiative alone are extraordinarily high. At the same time, family planning programs can and should mount effective preventive education programs aimed at decreasing the spread of STDs and HIV/AIDS. Where possible, in terms of budget, programs also need to encourage the testing, counseling, and treatment needed for these conditions.

Teen pregnancy has been essentially ignored by USAID programming in the past and this should change. As in the U. S., this is an urgent problem throughout the world, needing much more concerted efforts than have taken place to date in most developing countries.

The time has come to make major efforts to reduce the number of women tragically dying unnecessarily from pregnancy-related complications. Widespread availability of contraceptive services will help significantly. In addition, USAID should join with other agencies to forge a real partnership to make certain that all women have access to emergency obstetrical services.

Finally, and clearly the most controversial, USAID must take a lead in helping to decrease the unnecessary mortality secondary to a botched abortion. Early treatment of incomplete abortions would be a dramatic step forward, and such programming is possible within existing budgetary constraints.

I have tried to summarize some of the issues I believe USAID's Office of Population has to face in the coming years. This is, indeed, an exciting opportunity, one which I hope USAID and all of us will grasp effectively.

Thank you.

A

POPULATION AND HEALTH: NEW STRUCTURE, NEW STRATEGY

The Global Bureau Three factors contribute to the decision to create USAID's new Bureau for Global Programs, Field Support and Research:

- The end of the Cold War offers the opportunity to address new and/or previously neglected issues.
- Budget constraints force USAID to "work smarter."
- Husbanding and rebuilding technical staff at USAID is a priority. For example, there are 50 fewer PHN officers than there were a decade ago.

The Global Bureau will have a service orientation and will include the following functions:

- Technical assistance support and advice for USAID Missions and USAID/Washington.
- Management of field programs.
- Scientific and technical leadership for USAID.
- Career management for USAID's technical cadre.
- Donor coordination and representation on technical matters.
- Field-relevant research.

Five Centers will be established (Population/Health/Nutrition, Environment, Economic Development, Human Capacity Development, and Democracy) to undertake these functions in their respective technical areas. The common elements of each Center within the Bureau include the Director, responsible for leadership and coordination; the Deputy Director, responsible for professional/career management and "customer service" orientation; and the units for field and program support.

Questions & Answers

- Q:** What about women-controlled methods, teen programs, and male involvement? Are these priorities?
- A: (Maguire)** Yes, they are all priorities. The Office of Population wants to reach underserved groups, especially teens and men.
- Q:** Integration with other development projects might be mutually beneficial, particularly given USAID's new development paradigm which encourages such integration.

- A: (Van Dusen)** Absolutely. Working groups at the USAID/Washington level, such as the Water Working Group and the Reproductive Health Working Group, can promote these linkages. Missions will also be developing their own integration strategies, where relevant.
- Q:** How can we expand quality of care? Maintaining the focus on fertility reduction has not been mentioned.
- A: (Daulaire/Maguire)** Yes, fertility reduction is important. The contraceptive prevalence rate is still an important indicator of program success, but not the only one.
- Q:** Who is responsible for primary backstopping? Where does final authority lie?
- A: (Daulaire/Maguire)** The Global Bureau will be responsible for technical oversight. Leadership on strategic policy issues will be exercised by PPC in collaboration with the Global Bureau and the regional bureaus.
- Q:** How will the four components (population/health/nutrition, environment, economic development, and democracy) of USAID's new development paradigm be integrated?
- A: (Gillespie)** At the USAID/Washington level, the creation of working groups with budget authority and working group responsibilities established as part of the members' job descriptions is being considered. The Global Bureau will **not** be coordinating everything, but rather collaborating where needed in a phased process.
- Q:** May CAs work in countries where USAID Missions are closing?
- A: (Daulaire/Gillespie)** Current priority countries will not be dropped, and USAID's programs will not radically change in the immediate future. Selected activities will be considered in close-out countries; however, there will be no new major efforts. Also, funds must be leveraged from other donors.
- Q:** Will success be rewarded? Criteria for "small but successful" priority countries could be developed.
- A: (Daulaire)** USAID has latitude to develop such criteria within the current policy framework.

B

USAID'S REORGANIZATION: EFFECTS AT THE FIELD LEVEL

Carol Lancaster

USAID's Reorganization. This reorganization is the most extensive change USAID has ever experienced. The changes being undertaken are long overdue. The goal of the reorganization is to make USAID more streamlined and efficient and allow it to operate with greater teamwork. The process is nearly complete.

Implications of the reorganization for the field include reassurance that

- USAID will maintain strong technical capacity in the Global Bureau.
- USAID Missions will maintain the right to declare what is needed in the field.

USAID's Budget. The FY 94 budget for USAID is likely to be cut substantially, and final decisions are imminent. These cuts underscore the need to reduce the number of countries in which USAID operates.

Reform of Procurement, Planning, Implementation, and Evaluation. USAID's goal is to ensure simpler, more flexible, and quicker-responding programming capacity. New, broader strategies have been developed. Implementation guidelines are currently being developed.

Rewrite of the Foreign Assistance Act. The new rewrite will be a charter instead of a detailed piece of legislation. It will be a simpler bill.

Mark Schneider

Latin America and the Caribbean Bureau. Democracy is now the preferred and preeminent form of government in Latin America and the Caribbean. The Clinton administration is committed to strengthening democracy in the hemisphere.

Success lags, however, in other areas. Poverty is widespread, as 60 million more people in the region have dropped below the poverty line during the last decade. The TFR averages 5. An additional 5,000 new HIV infections occur each week, and 500,000 preventable infant deaths occur each year.

Access to and sustainability of family planning services remain major issues in the region. Site visits by Brian Atwood and Mark Schneider to Mexico City slum programs underlined this reality.

USAID still operates vertical ("stovepipe") programs. Hopefully a change to more integrated programs will meet the wide range of needs at the community level. USAID should use family planning and health

programs as a way to help in other areas, such as voter registration and microenterprise development.

Jerry Wolgin

Africa Bureau. Population programs in Africa have become the centerpiece of many Africa USAID Mission programs. It is the regional bureau's intention to maintain this priority.

Family planning programs in Africa evoke optimism. For the first time success is being seen in family planning efforts beyond the currently acknowledged success stories of Kenya and Zimbabwe. Demographic transition, for example in Ghana, is beginning. This, however, is just the tip of the iceberg. Significant unmet need still exists.

Nine of the 21 USAID Missions being closed are in sub-Saharan Africa. Hopefully, child survival, HIV/AIDS, and family planning work will be continued in some close-out countries through regional programming efforts. There may be setbacks initially, but progress will follow. Bilateral programs will be strengthened and commitment to family planning in Africa will continue.

William Jansen

Asia/Near East Bureau. Most of the region's technical staff will reside in USAID Missions, and the A/NE Bureau will turn to the Global Bureau for technical support.

The schedule for USAID Mission close-outs is as follows:

FY94: Afghanistan and the South Pacific

FY95: Thailand, Tunisia, and Pakistan

FY96: Oman

Some of the region's countries have the longest running national family planning programs in the world. Performance plateaus have been reached in some of these programs. Questions which need to be asked now include, Are the service modalities used in these national programs the best to respond to people's needs? Should USAID be reassessing these programming strategies and looking at other programming modes?

Asia offers opportunities for investment and new options. USAID resources alone will not be sufficient to meet these needs. Cooperation with other donors is needed.

USAID Missions may not be structured and staffed to undertake this critical analysis of national programs and USAID's support thereof. The regional bureau will need to contend with this.

Barbara Turner

Europe and New Independent States. The abortion issue in East Europe and the NIS is horrendous. There are human rights and

women's rights issues that need to be addressed. Abortion is the prime contraceptive method in the NIS, and efforts to expand contraceptive choice are encountering significant obstacles.

Most countries in the NIS have negative rates of growth. Basic USAID family planning programs have been focused on the Central Asian Republics where fertility rates are higher.

USAID is not working in the NIS in the long term but only four to 10 years. Some NIS countries are relatively wealthy compared to developing countries, and it does not make sense to provide assistance to them in the same manner as developing countries. Programs must also be health related, which is not always the case for other country programs. There are more players involved in the budgeting and programming process in the NIS than in other countries, with a consequent slowing of this process. It is important to note that, to these players, family planning in the NIS is not a top priority.

Beyond viewing family planning needs in the larger context of health, three programmatic concerns should be addressed:

- Local production of contraceptives. NIS countries have the ability to manufacture their own contraceptives. USAID should work with them to accomplish this.
- Training. People in NIS countries feel strongly that they need to develop their own programs that are appropriate for their position—not programs developed in other countries and applied to the NIS.
- Service Delivery. Programs should be thought out in terms of **integrated** health delivery systems for both primary and advanced care.

Larry Saiers

Policy and Program Coordination Bureau. There are three words to remember during this time of reorganization:

- Synergy. USAID needs to look for the interrelationships between its four strategies and where and how they can be maximized.
- Results. As with Vice President Gore's campaign to reinvent government, USAID needs to seriously deliver on targeted outputs.
- Sustainability. This term has always been in USAID's lexicon, but it has not been taken seriously until now. More harm than good can be done if this objective is not kept at the forefront at all times.

USAID must continually think of resource allocation trade-offs that are entwined in all decisions. These become all the more critical in a time of declining budgets. Questions of trade-offs ultimately come back to the three key considerations noted earlier: synergy, results, and sustainability. These decisions are a joint responsibility between management and PPC.

Questions & Answers

- Q:** How will USAID/Washington get the word to USAID Mission directors to ensure that they follow the new directions and strategies?
- A (Lancaster):** This is not a problem. USAID Mission directors are being contacted through a variety of forums.
- Q:** With cutbacks in FY94, there is concern that child survival will not continue to be funded as a discrete line item. Where does it stand this year?
- A (Van Dusen):** The child survival program will not be cut disproportionately. In fact, the child survival program has been protected to the degree that it has taken a smaller decrease than the rest of the development assistance account.
- Q:** How have the Global Bureau, regional bureaus, and PPC collaborated in the reorganization, and what does this mean for program support for the field?
- A (Van Dusen):** Technical support for Missions will be the responsibility of the Global Bureau. To accomplish this, however, USAID leadership recognizes that the Agency's technical capacity must be built up again.
- Q:** Regarding the NIS, how or where are decisions being made on programming?
- A (Turner):** The decision process is being coordinated by Strobe Talbott, Deputy Secretary of State, but there are many people in the U.S. government with opinions. Within this group of players, however, fertility and population are not ranked among the top five problems for the NIS.
- Q:** From the field, this reorganization looks like more centralization, as evidenced by this conference and its sparse attendance by USAID field personnel. Any response?
- A (Neuse):** Part of that impression may be unfounded. It was not known how many field people would be attending this conference until very recently.

C

FAMILY PLANNING INITIATIVES

Jim Shelton

Public Health Approach. A “public health approach” to family planning acknowledges the scarcity of resources and calls for the prioritization of interventions based on the seriousness of the problem and the potential effectiveness of proposed interventions. This approach will result in the greatest good for the greatest number.

Maximizing Access and Quality of Care (MAQ). Both access and quality are key elements of family planning programs. They are important at both the level of the individual client and the general population. Although there is some “creative tension” between access and quality, there is also a great amount of consonance between the two.

Contraceptive Choice. Assurance of contraceptive choice is the hallmark of USAID’s effort in family planning and will be continued.

Breastfeeding. Breastfeeding is an especially important public health intervention, as it saves lives and lowers fertility. It is an essential element of reproductive health. The lactational amenorrhea method (LAM) does not receive enough attention from the CA community, despite data which show that LAM attracts new clients and facilitates their transition to other family planning methods.

Gender. The population and health community has only begun to recognize the influence gender has on its programs. All must work to reduce gender inequities.

Emergency Contraception. Combined oral contraceptives (OCs) can be used as post-coital contraception. The dosage is two standard-dose (or four low-dose) pills within the first 72 hours followed by another two (or four) pills 12 hours later. Nausea and vomiting may result.

Abortion. Within the wide range of activities relating to abortion and on the basis of consultation with the General Counsel, USAID-funded CAs can perform the following:

- Studies on abortion incidence, determinants, consequences, and related issues.
- Provision of post-abortion contraceptive services.

Activities that CAs **cannot** perform include

- Paying for abortions “as a method of family planning.”
- Biomedical research on methods of abortion as a means of family planning.

- Lobbying for abortion.

Treatment of septic or incomplete abortions must be carefully addressed. USAID is prepared to provide training in treatment of septic or incomplete abortions. However, because such training is closely related to the provision of abortion, care must be taken to evaluate situations on a case-by-case basis.

Jane Bertrand

This presentation was based on the paper, "Access, Quality of Care, and Medical Barriers in International Family Planning Programs," prepared by Jane Bertrand, Bob Magnani, Karen Hardee, and Marcia Angle.

The functional areas of family planning programs (management, training, logistics, IEC, research, and policy) all have an impact on the access and quality of a given program, both of which affect utilization of services.

Access can be thought of as the combined result of several factors (physical, economic, administrative, cognitive, psychosocial, etc.) that impede or facilitate a client's ability to get to the door of the service delivery point (SDP). Quality may be thought of as the combined result of factors that affect the adoption and continuation of use once the client is inside the service facility (as described in the Bruce/Jain framework).

Many of the elements in USAID's Medical Barriers Initiative are closely linked to quality of care. Examples include client eligibility criteria, overly restricted limits on providers, provider bias, and the management of side effects.

One concern about quality is in the cost arena: how much will quality improvements cost, and will those additional costs lead to fewer services somewhere else? Quality is relative and need not be expensive. Quality assurance is above all a matter of introducing a mind-set which focuses on the needs of the client.

Following are some concerns about the Medical Barriers Initiative:

- It inadvertently may encourage the removal of some genuinely protective safeguards to health.
- It may result in a reduction of reproductive health services for some women. At issue, e.g., is whether contraception should be held hostage to other services. If USAID is wedded to choice, clients should be allowed to choose.
- It may result in an orientation of program managers to quantity rather than quality. Access and quality must not be viewed in zero-sum terms.
- It consumes resources that could be used to improve quality. The Initiative was undertaken because it was actionable.

Quality and access are not diametric. By recognizing that both are interlinked and important, a “win-win” situation can be created in which improved, client-oriented services and increases in contraceptive prevalence are the result.

Questions & Answers

Comment: Family planning programs have an impact on reproductive health (not just on CPR). This impact is not adequately reflected in the indicators that family planning programs use. A reproductive rights/health approach may not always lead to demographic impact. It must be clarified which objective will take precedence and the indicators adjusted accordingly.

Comment: Breastfeeding does not receive enough attention from the family planning community. The word “breastfeeding” should appear in the new Foreign Assistance Act rewrite. Many women complain that they cannot get access to and information on a wide range of methods. Female-controlled barrier methods need to be included as an essential element of family planning commodity assistance programs. “Sustainability” is an oft-used term, but rarely applied to our own overconsumption of natural resources. The developed world should take overconsumption into consideration before blaming women for their “excessive fertility.”

Q: It is important to disseminate the evidence that investments in quality lead to improved contraceptive use. Is USAID planning to conduct more research in this area?

A (Shelton): One study showed that people were more likely to continue using a method if it was the one they wanted. Yes, USAID will conduct more research in this area.

D

REPRODUCTIVE HEALTH: PROGRAMMATIC ISSUES AND CONSTRAINTS

Margaret Neuse

USAID is adopting a new mandate in reproductive health, the importance of which is reflected in some grim facts: each year there are 500,000 maternal deaths and 25 million new cases of AIDS.

Reproductive health encompasses a wide range of potential interventions. Although USAID does not anticipate working in all aspects of reproductive health, three priority areas will receive special attention:

- Safe regulation of fertility
- Safe pregnancy and maternal nutrition
- Prevention and management of HIV and STDs

As USAID seeks to address these aspects of reproductive health, it will **not** diminish its efforts in family planning. Proposed interventions in reproductive health will respect the predominant role of family planning, address priority problems, and be actionable and cost-effective. The first step is to add activities to the current USAID portfolio, such as community-based distribution, IEC, postpartum services, training, condom promotion, policy dialogue, and operations research.

USAID must target its resources strategically and look for synergy among the elements of existing programs. New programs and projects can also be implemented.

The Office of Population has initiated a survey on reproductive health—the first step in obtaining a better, in-depth view of the new focus on reproductive health. Responses to key questions are outlined below.

USAID Missions gave priority to three areas for possible program linkages:

- family planning
- HIV/AIDS
- maternal health

A variety of funds, i.e., in addition to population funds, would be used to support these linkages.

The most frequent suggestions by respondents included the following:

- Achieve a broader reproductive focus.
- Construct a clear definition of reproductive health.
- Combat AIDS.
- Address the treatment of STDs.

- Promote better collaboration between the Offices of Health and Population.

On which areas should USAID focus next?

- Family planning
- Safe motherhood
- Primary prevention of STDs

Other reproductive health concerns:

- Female genital mutilation
- Sex behavior
- Breastfeeding

Related areas include

- Child survival programs
- Female education
- Environment

Additional suggestions concerning USAID's new focus on reproductive health include

- Linking resources
- Targeting adolescents
- Moving further and faster with operations research

The key to developing good programs will be flexibility.

Paul Delay

USAID needs to critically consider what options are available for addressing HIV/STDs through family planning services. There are 250 million new cases of STDs per year, underscoring the desperate need to increase STD surveillance. USAID should focus on the traditional family planning clients—women—who need and want information.

There are numerous advantages to including STD management activities within the array of services offered by family planning clinics:

- The clinics' access to women provides an opportunity to address wider women's health needs and an opportunity for women to seek care for a variety of these needs.
- The prevalence and severity of STDs in women can be monitored.
- The impact of STDs on contraceptive selection and use is an important quality of care issue.
- Existing STDs can increase the efficiency of HIV transmission five to 20 times.

Syndromic management is a recommended method for treating STDs. This method of treatment addresses all possible causes of symptoms particular to a certain setting. Syndromic management has proven simple and cost-effective, allows for diagnosis and treatment in one visit, can be used on a large scale, and can be provided by a broad range of

health care staff. The obstacles to syndromic management of STD cases include the lack of sensitivity for women, the inability to address asymptomatic cases, limited resources, the stigma associated with STD treatment, and the need for physical space and equipment.

For maximum public health impact on the STD epidemic, it is most important to treat core carriers of STDs. Generally, clients of family planning clinics are not core carriers. Care needs to be taken when selecting indicators.

Steps USAID should take to address STDs within family planning programs:

- Introduce primary prevention activities in as many settings as possible.
- Determine what family planning programs have accomplished in the area of STD prevention and management.
- Identify appropriate family planning settings in which to incorporate STD management.
- Carefully document lessons learned and demonstrated successes.

Mary Ann Anderson

Family planning is a key intervention to promote safe motherhood.

Africa has the highest maternal mortality ratio due to the following causes:

- Hemorrhage
- Unsafe abortions (the most preventable cause)
- Infection
- Obstructed labor

In addition to the number of women who die from maternal causes, another 50 million women suffer permanent chronic complications.

For these reasons, USAID needs to combine family planning efforts with maternity care. Policy reform is important, for example, to remove medical barriers. The role of the nurse-midwife needs to be strengthened.

Family planning and maternity care work well together because they have the same clients, workers, and service delivery sites. Family planning and maternity care can be linked through training, IEC, and service delivery.

Judith Senderowitz

Childbearing in the teen years remains high in many places. One reason it has become easier to address this issue is because the risks and consequences of early childbearing are now better understood. Teenage pregnancy and early childbearing carry significant socioeconomic risks and can greatly alter a woman's life options.

IEC is the key element to reaching adolescents.

Recommended USAID actions with regard to adolescents include

- Expand the target audience to include unmarried women.
- Link family planning with HIV/STD prevention programs.
- Promote safe abortion.
- Expand IEC campaigns.
- Conduct research and evaluation.

Adolescents face many barriers to access of family planning services, including the powerlessness of young women. What is needed most is leadership, especially at the international level. This is a major challenge in search of a political advocate.

Questions & Answers

Comment: Women should be shown in a more positive light in IEC campaigns, not just as prostitutes or other negative images of women.

Q: There continues to be mixed messages about involvement in unsafe abortions. What can USAID do?

A: With only \$15 million to spend worldwide, USAID cannot initiate much. More funds are needed before more can be done.

E

PROGRAMMATIC AND IMPLEMENTATION ISSUES AND DIRECTIONS

Duff Gillespie

The following factors have contributed to the successes of USAID's population program to date:

- Clearly defined objectives.
- A critical mass of resources, including CAs.
- Emphasis on evaluation and relatively quantifiable results.
- Strong policy commitment.
- Diverse approaches to bringing about systemic change (i.e., not just building clinics).

Expectations in the population community are currently high, given new directions in reproductive health. The challenge is to translate these new directions into interventions that have impact and at the same time fulfill the objectives of the population program.

Limited funds from the population account will be made available in FY94 for related reproductive health interventions. In addition, in FY95, pilot activities may be funded in female education or other activities designed to enhance the demand for family planning. Given these possibilities, USAID should keep the following points in mind when moving forward with the population program:

- USAID should be realistic about the amount of time it takes to move the program in new directions.
- The interventions USAID chooses must be empirically based and results driven.
- The allocation of funds should be based on performance.
- The tools and costs of interventions should be understood.
- False starts and mistakes will be made at times.

Several issues remain to be addressed, particularly in determining how to maintain impact in family planning while expanding into other areas. USAID needs to break away from a project-oriented approach and consider "sectoral" interventions appropriate to specific countries. USAID needs advice, especially from the field, on the optimal objectives to pursue in reproductive health. Finally, good indicators for new interventions need to be developed.

F

TRANSLATING STRUCTURE AND STRATEGY OF THE NEW USAID TO OPERATIONS

This session was held following two plenary sessions and several working groups, meetings which examined the programmatic and operational implications of “The New USAID.” The purpose of the panel was to respond to recommendations/questions developed during the previous meetings.

Administrative Issues

Some key precepts to the re-engineering process called for USAID management to

- Start with a “blank sheet” when considering possible reforms.
- Focus on the needs of the “customer,” the end-user, and the beneficiary.
- Improve quality and use of information technology.
- Empower managers while encouraging a “team” approach.
- Focus on **results and accountability**. Shift away from a projects focus and stress new combinations which will realize strategic objectives.

USAID should be identified as an agency, not a collection of bureaus.

Procurement. The Office of Procurement acknowledges significant problems, including staffing constraints (35 vacancies), a very complex budget process, and outdated technology. The Office of Procurement has consequently developed an 18-point reform agenda aiming at **simplification, consistency, and efficiency**.

Examples of **simplification** include greater use of pre-award audits and a reduction in the number of clearances required for routine transactions, especially for small procurements. **Consistency** will be improved by the use of standardized contract language. Gains in **efficiency** will improve precision in the short term and increase flexibility in the longer term.

A major recruitment effort is underway to fill vacancies in the Contracts Office. A series of “town meetings” on procurement will be held to solicit client views on procurement issues.

Some acquisition/assistance issues, e.g., “add-ons” to cooperative agreements, will be reviewed and resolved at a later date. PHN procurement functions/staff will **not** move to the Global Bureau.

The breadth and impact of the procurement reform process must, however, be kept in perspective:

- USAID can change only those elements which are within USAID's control.
- Changes in government procurement in general are part of the re-invention. USAID's total procurement is very small compared with other U.S. government agencies.

Streamlining will involve

- Permitting grant officers to sign certain contracts without supervisory review.
- Putting a systems approach in place that reduces paper and unnecessary procedures.

Performance-based contracting will reduce controls on inputs.

New policies are not effective within a restrictive system. PPC will play a key role to ensure that individual country strategies are objectives oriented. The Global Bureau will provide technical strength to the process.

The country strategy will be the basic guide for planning at the country level, implying the near-elimination of "projects" as such. Country-level managers, with G/PPC advice and inputs, will request technical assistance and services, as required to implement the country strategy.

USAID is attempting to move away from functional categories in the development budget (with population as an exception). More emphasis on non-project assistance may nonetheless require USAID to develop other means to monitor spending in certain areas. At present, documents that claim to describe non-project assistance look suspiciously like project documents. More radical change is likely.

USAID is months or years away from a mechanism to mesh donor- or CA-coordination with performance-based budgeting.

Programming Issues

Priority Country List. The list will be ready by the end of March or early April 1994. G/PPC and the geographical bureaus will propose priority countries which reflect strategic interests in PHN, democracy, environment, and economic development. Global resources will be concentrated in these priority countries, but non-priority countries may still be considered for selected interventions.

Key criteria for PHN priority countries will be population size, magnitude and intensity of the problem, and prospects for successful intervention. A single POP/MCH list is possible with little deviation from the current lists, but some variation in relative weight may occur. POP and MCH will have the same priority countries. The HIV/AIDS list will be developed separately.

Fate of Non-Priority Countries. If country activities do not contribute significantly to the realization of global objectives, they cannot expect to receive a large share of resources. Those not included as priorities may wish to “try again.” There will be less emphasis on sectoral activities.

Coordination Among CAs. Incentives for CA collaboration will be built into projects. Donor coordination is also needed to increase the total population/health effort.

Indicators. USAID needs to establish broad, cross-cutting indicators in order to measure impact, for example, on adolescents. The Global Bureau, PPC, and regional bureaus will oversee the development of indicators which will be proposed to senior management and USAID Missions. However, as USAID expands into other areas, intermediate progress or intersectoral progress needs to be measured.

USAID’s first priority within the population sector will remain family planning. Programs will be results-driven. The most important global indicators for PHN will be, in order of priority, the following:

- Fertility
- Child mortality
- Maternal mortality
- Reductions in the spread of HIV/AIDS

The respective weights of these priorities will vary within specific programs. Moreover, 10 percent of the budget may be available for small-sale activities that are expected to increase family planning use.

There will be an expansion of working groups linking population and health. Some of these groups will include CAs, others will not. Working groups of varying composition will help to identify indicators once they have established clear priorities and intervention strategies. Unfortunately, in many cases at the country level, budgets will be inadequate to support the development of truly sustainable activities.

Working groups in POP/Health currently include Reproductive Health, Health Care Financing and Policy, HIV-TB, and Policy. Working groups are beneficial, but process must not be confused with product.

Expanded Interventions and Contracting Implications. A broadening of PHN interventions may require revisions of cooperative agreements and Scopes of Work. Blanket waivers are being considered by the Office of Population, for example, for right-hand drive vehicles for Africa and India.

Future Role of Specialized CAs. At present, USAID Mission contracts tend to disfavor specialized CAs and favor multiple-service institutions. This trend reflects non-priority countries’ relatively difficult access to central funds. The key problem for USAID Missions is a lack of adequate staff for coordination.

There will be a mixture of general and specialized projects, utilizing the comparative strengths of specialized CAs. Some skills are highly specialized, e.g., IEC or scientific research, and they should be utilized.

USAID and the CAs need to determine which activities—beyond family planning—CAs should adopt. In FY95 up to 10 percent of POP funds may be made available for such purposes. Funding decisions in the field of reproductive health will be guided by operations research and demonstration projects which will document what works.

Smaller CAs should not be deterred from the bidding process. How can CAs contribute their expertise to developing strategies without eliminating themselves from competition?

Reduced USAID Presence. USAID needs to get smaller to get stronger.

“At-risk Programs.” There is concern that the population programs of some of the poorer “close-out” countries may backslide following the close-out of USAID Missions. However, USAID’s problem is simple: the operating expenses budget must be reduced. USAID has been praised by the Office of Management and Budget and Capitol Hill for its move to close USAID Missions. “Out is out,” absent compelling justification to continue selected activities in a close-out country. In the fields of population, AIDS, and related research, some exceptions may be possible if they are closely linked to global priorities. USAID Missions that are closing will not take on new activities. It is unlikely that more staff will be sent to the field, and the number of personal services contracts (PSCs) will be reduced.

TUESDAY - FEBRUARY 22, 1994

7:00-8:30	Registration and Continental Breakfast
8:30-9:00	Welcome, Announcements, Objectives of the Meeting <u>Speakers:</u> Maria Busquets-Moura, Meeting Chairperson Elizabeth Maguire, Acting Director, Office of Population
9:00-10:15	The New USAID <u>Speaker:</u> J. Brian Atwood, Administrator, USAID Discussion
10:15-10:45	Break
10:45-12:15	Plenary A Population and Health: New Structure, New Strategy <u>Panel Moderator:</u> Ann Van Dusen, Acting Assistant Administrator for Bureau for Global Programs, Field Support, and Research (G) <u>Panelists:</u> Duff Gillespie, Acting Deputy Assistant Administrator for G Elizabeth Maguire, Acting Director, Office of Population Nils Daulaire, Senior Advisor on Population and Health, Bureau for Policy and Program Coordination Discussion
12:30-2:00	Luncheon Program: The Road to Cairo and Beyond: Taking Leadership on Global Issues <u>Speaker:</u> Timothy Wirth, Counselor, U.S. Department of State Discussion
2:15-2:45	Population: Progress and Challenges <u>Speaker:</u> Steven Sinding, Director, Population Sciences, The Rockefeller Foundation
2:45-4:15	Plenary B USAID's Reorganization: Effects at the Field Level <u>Panel Moderator:</u> Carol Lancaster, Deputy Administrator, USAID

Panelists:

Mark Schneider, Assistant Administrator for Latin America and the Caribbean

Ann Van Dusen, Acting Assistant Administrator for G Bureau

William Jansen, Chief, Development Resources, Human Resources Department

Barbara Turner, Acting Deputy Assistant Administrator for Europe and the NIS

Jerry Wolgin, Acting Deputy Assistant Administrator for Africa

Larry Saiers, Deputy Assistant Administrator, Bureau of Program and Policy Coordination

Discussion

4:15-4:45

Break

4:45-6:00

Effects of Changes for the Population Program and How USAID Does Business

Reactions and Discussion of Changes in Break Out Groups

6:30-8:30

Reception

WEDNESDAY - FEBRUARY 23, 1994

7:00-8:30

Registration and Continental Breakfast

8:30-9:00

Announcements, Presentation of Summary of Small Group Conclusions from Day 1

9:00-9:30

Family Planning and Reproductive Health: Overview and Vision

Speaker:

Allan Rosenfield, Dean, School of Public Health,
Columbia University

9:30-10:15

Plenary C

Family Planning Initiatives

Speakers:

Jim Shelton, Acting Deputy Director, Office of Population
Jane Bertrand, The EVALUATION Project, Tulane University,
School of Public Health and Tropical Medicine

Discussion

10:15-10:45

Break

10:45-12:15

Break Out Groups

1. Maximizing Access and Quality of Care
2. DMPA: What's Next?
3. NORPLANT® Implants
4. Opportunities and Issues in Postpartum Family Planning Services
5. Post-Abortion Care
6. Increasing Involvement of Men in Family Planning
7. Building Sustainability in Family Planning Programs
8. Focusing on Results--Evaluation
9. Gender Planning in Population: Strategies for Implementation

12:30-2:00

Luncheon Program: Population: The View from the Hill

Panel Moderator:

Jill Buckley, Assistant Administrator for Legislative and Public Affairs

Panelists:

Kelly Kammerer, Agency Counselor

Jim Bond, Minority Staff Director, Subcommittee on Foreign Operations,
Senate Appropriations Committee

Pam Norick, Legislative Assistant, Senator Patty Murray

Kate Grant, Staff Member, House Foreign Affairs Committee

Diane Ohlbaum, Staff Member, Senator Paul Sarbanes, Senate Foreign
Relations Committee

Discussion

2:15-3:30

Plenary D

Reproductive Health: Programmatic Issues and Constraints

Panel Moderator:

Margaret Neuse, Deputy Director, Office Of Population

Panelists:

Paul Delay, HIV/AIDS Division, Office of Health

Mary Ann Anderson, Health Services Division, Office of Health

Judith Senderowitz, Consultant

Discussion

3:30-4:00

Break

4:00-5:30

Break Out Groups

10. Reproductive Health for Adolescents
11. Addressing the Prevention of HIV/STDs in Family Planning Programs
12. Female Circumcision/Female Genital Mutilation
13. Sexuality Issues for Family Planning Programs
14. Breastfeeding and Family Planning: Providing Benefits for Mother,
Child and Family
15. Maternal and Neonatal Health and Nutrition
16. Linkages of Family Planning with Female Literacy and Education
17. Linkages Between Family Planning and Child Survival Programs
18. Linkages with Environmental Groups and Programs

THURSDAY- FEBRUARY 24, 1994

7:30-8:30	Registration and Continental Breakfast
8:30-8:45	Announcements, Summary of Conclusions of Day 2
8:45-9:45	The New USAID: Streamlining Operations <u>Speaker:</u> Larry Byrne, Assistant Administrator for Management Discussion
9:45-10:15	Break
10:15-10:45	Plenary E Programmatic and Implementation Issues and Directions <u>Speaker:</u> Duff Gillespie, Acting Deputy Assistant Administrator for G
10:45-1:00	Break Out Sessions: 1. Administrative Issues (e.g. streamlining processes; buy-ins; contracting practices) <u>Panel Members:</u> Fred Will, Office of Procurement Phyllis Dichter-Forbes, Deputy Assistant Administrator, Bureau for Management 2. Key Implementation Issues: LAC; AFR; A/NE; ENI 3. Key Programmatic and Impact Issues (in two sets of groups): LAC; AFR; A/NE
1:00-3:00	Lunch (No program) (Rapporteurs from Working Groups meet to prepare report summaries)
3:00-5:00	Plenary F Translating Structure and Strategy of the New USAID to Operations: Reporting of Recommendations; Panel Response <u>Panel Moderator:</u> Margaret Neuse, Deputy Director, Office of Population <u>Panelists:</u> Duff Gillespie, Acting Deputy Assistant Administrator for G Bob Wrin, Acting Director, Office of Health Nils Daulaire, Senior Advisor on Population and Health Fred Will, Office of Procurement Discussion
5:00-5:30	Closing Remarks and Next Steps <u>Speaker:</u> Elizabeth Maguire, Acting Director, Office of Population

BREAK OUT GROUPS SPEAKERS LIST

1

MAXIMIZING ACCESS AND QUALITY OF CARE (MAQ)

Leaders/Speakers:

Jinny Sewell, Office of Population
Leslie Curtin, Office of Population
Karen Hardee, Family Health International
Jane Bertrand, The EVALUATION Project, Tulane University

2

DMPA: WHAT NEXT?

Leaders/speakers:

Doug Huber, Pathfinder International
John Haaga, National Academy of Sciences
Juan Diaz, The Population Council
Laurie Liskin, Center for Communication Programs,
Johns Hopkins University
Deirdre LaPin, Office of Population
Erin McNeill, Office of Population

3

NORPLANT[®] IMPLANTS

Leader/speaker:

Martha Brady, The Population Council
Davy Chikamata, The Population Council
Joseph Dwyer, AVSC International
Nancy Newton, PATH
Felice Apter, Office of Population

4

OPPORTUNITIES AND ISSUES IN POSTPARTUM FAMILY PLANNING SERVICES

Leaders/speakers:

Jim Foreit, The Population Council
Beverly Winikoff, The Population Council
Miriam Labbok, Georgetown University
Carlos Cardenas, Pathfinder International
Cynthia Steele Verme, Association for Voluntary Surgical
Contraception
Roberto Rivera, Family Health International

5

POST-ABORTION CARE

Leaders/speakers:

Allan Rosenfield, Columbia University School of Public Health
Khama Rogo, University of Nairobi
Katie McLaurin, IPAS
Jan Neamatalla, Association for Voluntary Surgical Contraception
Nahid Toubia, The Population Council

6

INCREASING INVOLVEMENT OF MEN IN FAMILY PLANNING

Leaders/speakers:

Karin Ringheim, Office of Population
Cecilia Ndeti, The Population Council
Ricardo Vernon, The Population Council
Opiah Mensah Kumah, Population Communication Services,
Johns Hopkins University
Nick Danforth, Association for Voluntary Surgical Contraception
Terrence Jezowski, Association for Voluntary Surgical Contraception

7

BUILDING SUSTAINABILITY IN FAMILY PLANNING PROGRAMS

Leaders/speakers:

Janet Smith, The Futures Group, OPTIONS II
Marcia Townsend, IPPF/WHO
Michael Van Vleck, PROFIT/Deloitte and Touche
Catherine Crone Coburn, Management Sciences for Health, FPMD
Don Levy, The Futures Group, SOMARC

8

FOCUSING ON RESULTS—EVALUATION

Panel Moderator:

Amy Tsui, Director of the EVALUATION Project, University of
North Carolina

Panelists:

Steven Sinding, The Rockefeller Foundation
Lynn Carter, PRISM Project, Management Systems International
Bill Goldman, USAID/Dhaka
Lynne Gaffikin, JHPIEGO

9

GENDER PLANNING IN POPULATION: STRATEGIES FOR IMPLEMENTATION

Leaders/speakers:

George Brown, The Population Council
Patricia Coffey, Office of Population
Magali Marquez, IPPF/WHO
Ann McCauley, Population Communication Services,
Johns Hopkins University

10

REPRODUCTIVE HEALTH FOR ADOLESCENTS

Leaders/speakers:

Doug Kirby, ETR Associates
Judith Senderowitz, Consultant
Alfonso Lopez Juarez, MEXFAM
Majorie Macieira, Center for Population Options

11

ADDRESSING THE PREVENTION OF HIV/STDs IN FAMILY PLANNING PROGRAMS

Leaders/speakers:

Willa Pressman, Office of Population
Jim Shelton, Office of Population
Elizabeth Lule, Pathfinder International
Nancy Williamson, Family Health International
Barbara Pillsbury, International Health and Development Associates

12

FEMALE CIRCUMCISION/FEMALE GENITAL MUTILATION

Leaders/speakers:

Asha Mohamud, Center for Populations Options
Nahid Toubia, The Global Action Against FGM project
Kathy Blakeslee, Office for Women in Development
Malika Ladjali, IPPF/London
Carol Corso, PATH/Mothercare

13

SEXUALITY ISSUES FOR FAMILY PLANNING PROGRAMS

Leaders/speakers:

Margarita Diaz, CEMICAMP, Brazil
Wayne Pawlowski, Planned Parenthood of Metropolitan Washington

14

BREASTFEEDING AND FAMILY PLANNING: PROVIDING BENEFITS FOR MOTHER, CHILD, AND FAMILY

Leaders/speakers:

Chloe O'Gara, WELLSTART
Miriam Labbok, Georgetown University
Sam Dickerman, WELLSTART - Honduras

15

MATERNAL AND NEONATAL HEALTH AND NUTRITION

Leaders/speakers:

Mary Ann Anderson, Office of Health
Marge Koblinsky, Mothercare
Sambe Duale, Academy for Educational Development
Phil Musgrove, The World Bank
Julia Walsh, Harvard University/DDM

16

LINKAGES OF FAMILY PLANNING WITH FEMALE LITERACY AND EDUCATION

Leaders/speakers:

Joseph Carney, USAID/Jakarta
John Comings, World Education

17

LINKAGES BETWEEN FAMILY PLANNING AND CHILD SURVIVAL PROGRAMS

Leaders/speakers:

Nils Daulaire, Policy and Programs Coordination, USAID
David Nicholas, University Research Corporation
Henry Mosley, Johns Hopkins University
M. T. Alaoui, Moroccan National Center for Reproductive Health
William Emmet, Consultant

18

LINKAGES WITH ENVIRONMENTAL GROUPS AND PROGRAMS

Leaders/speakers:

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Carlos Aramburú, Pathfinder International
Glenn Prickett, Policy and Program Coordination, USAID
Frank Zinn, University of Michigan
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LIST OF ABBREVIATIONS

AFR	Africa Bureau (USAID)
AIDS	acquired immunodeficiency syndrome
AIDSCAP	AIDS Control and Prevention Project
A/NE	Asia and Near East Bureau (USAID)
AVSC	Association for Voluntary Surgical Contraception
CA	Cooperating Agency
CORA	Center of Orientation for Adolescents (Mexico)
CPR	contraceptive prevalence rate
DHS	Demographic and Health Surveys
DMPA	Depo-Provera (trade name for depot medroxy-progesterone acetate)
ENI	Europe and New Independent States Bureau (USAID)
FGM	female genital mutilation
FY	fiscal year
G	Bureau for Global Programs, Field Support and Research (USAID)
HIV	human immunodeficiency virus
IEC	information, education, and communication
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
IUD	intrauterine device
LAC	Latin America and the Caribbean Bureau (USAID)
LAM	lactational amenorrhea method
MAQ	maximizing access and quality of care
MCH	maternal and child health
MEXFAM	Fundacion Mexicana para Planificacion Familiar (IPPF affiliate)
NGO	non-governmental organization
NIS	new independent states
OC	oral contraceptive
ODA	official development assistance
PATH	Program for Appropriate Technology for Health
PHN	population, health, and nutrition
POP	Office of Population (USAID)
PPC	Program and Policy Coordination Bureau (USAID)
PSC	personal services contract
PVO	private voluntary organization
RFP	request for proposal
SDP	service delivery point
STD	sexually transmitted disease
TB	tuberculosis
TFR	total fertility rate
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
U.S.	United States
USAID	United States Agency for International Development
WHO	World Health Organization
WID	Office of Women in Development (USAID)

